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

STATE OF ILLINOIS,
ILLINOIS WORKERS' COMPENSATION COMMISSION,

Petitioner,

18IWCC0346

vs.

NO: 08 INC 650

NASER ALSHOWEAT, Individually, and as President of S.O.S. Auto Transport,

Respondent.

DECISION AND OPINION RE: INSURANCE COMPLIANCE

Petitioner, the Insurance Compliance Division of the Illinois Workers' Compensation Commission, brings this action, by and through the Office of the Illinois Attorney General, against the above-captioned Respondent, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act ("Act") and Section 7100.100 of the Rules Governing Practice Before the Illinois Workers' Commission ("Rules"), codified as 50 Illinois Administrative Code, Chapter 11. The Commission finds proper and timely notice were given to all parties.

Respondent was provided notice of an Insurance Compliance Informal Conference scheduled for June 26, 2013, on May 10, 2013. This conference followed correspondence informing Respondent on February 9, 2009, of its alleged non-compliance of the Act. Respondent failed to appear at the Insurance Compliance Informal Conference on June 26, 2013. In accordance with the Rules, the matter was set for a hearing before the Commission on June 19, 2014. Notice of the June 19, 2014, was mailed to both Petitioner and Respondent on March 31, 2014.

On June 19, 2014, the Insurance Compliance hearing was held and presided over by Commissioner Kevin W. Lamborn. At that time, the hearing was continued until August 21,

2014, due to Respondent's failure to appear and the failure of any counsel to appear on Respondent's behalf. Respondent and/or counsel representing Respondent failed to appear at August 21, 2014, hearing or the subsequent November 6, 2014, hearing. At the November 6, 2014, hearing a motion for a default finding of liability was made to and granted by Commissioner Lamborn. A prove-up hearing was scheduled for January 13, 2015, with notice of the January 13, 2015, hearing was mailed to Respondent on December 4, 2014. Respondent and/or counsel representing Respondent failed to appear at January 13, 2015, hearing.

The Commission finds Respondent was afforded multiple opportunities both informally and formally to demonstrate compliance with Section 4(a) of the Act. Respondent failed to appear or send counsel on its behalf to both the insurance compliance informal conference on June 26, 2013, and the multiple hearings before Commissioner Lamborn. Due to Respondent's failure to answer to the allegations of non-compliance with the mandatory insurance coverage provisions of the Act, the Commission enters a default judgment against Respondent for failing to comply with all pertinent provisions of the Act from July 20, 2005, to July 31, 2008, and from December 19, 2008, to April 4, 2010.

Respondent failed to comply with Section 4(d) of the Act for a total of 1,580 days. Section 4(d) provides that failure to comply with a citation issued by an investigator with the Commission may result in a civil penalty of up to $500.00 per day for each day of such failure to comply with each day constituting a separate offense. The Commission elects to assert this statutorily-prescribed authority and fines Respondent $790,000.00 for non-compliance of Section 4(a) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent Naser Alshoweat, individually and as President of S.O.S. Auto Transport, is found to be an employer in non-compliance with the insurance provisions of Section 4(a) of the Act and Section 7100.100 of the Commission Rules and is ordered to pay the Commission a fine of $790,000.00 pursuant to Section 4(d) of the Act and Section 7100.100 of the Rules.

Pursuant to Commission Rule 7100.100(f), once the Commission assesses a penalty against an employer in accordance with Section 4(d) of the Act, payment shall be made according to the following procedure: 1) Payment of the penalty shall be made by certified check or money order and made payable to the State of Illinois; 2) payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court of review after final adjudication to:

Illinois Workers' Compensation Commission
Fiscal Office
100 W. Randolph Street, Suite 8-328
Chicago, Illinois 60601
(312) 814-6625

Bond for removal of the 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 1 - 2018
KWL/mav
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

STEVEN SPAYER,

Petitioner,

vs.

NO: 13 WC 28581

NETCOM, INC.,

18IWCC0347

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, prospective medical treatment, notice, temporary total disability (TTD) and penalties and attorneys' fees, 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 appeals from the Arbitrator's award finding accident, notice, causal connection and finding Respondent shall pay the reasonable and necessary medical in Petitioner's Exhibits, one through sixteen, pursuant to sections 8(a) and 8.2 of the Act, travel reimbursement and prospective medical treatment plus penalties and attorneys' fees under sections 19(k), 19(l) and 16.

18IWCC0347

Based upon a review of the entire record, the Commission affirms the Arbitrator's finding of accident. The Commission also modifies the Arbitrator's Decision, and finds Petitioner failed to prove that he provided timely Notice of his work-accident to Respondent and Petitioner failed to prove his current condition of ill-being with respect to his gastroesophageal and gastrointestinal conditions is causally related to his January 29, 2013 work-related accident. The Commission reverses the Arbitrator's findings of causal connection between Petitioner's January 29, 2013 work accident and his gastroesophageal and gastrointestinal conditions of ill-being and of Notice.

Based upon the Commission's finding with respect to causal connection, the Commission further vacates the Arbitrator's award of medical expenses related to Petitioner's gastroesophageal and gastrointestinal conditions, vacates the Arbitrator's award of prospective medical services including the rehabilitation program recommended by Dr. Arora at Mayo clinic, vacates the award for reimbursement for travel to and from Mayo clinic and vacates the Arbitrator's award of penalties and attorneys' fees pursuant to sections 19(k), 19(l) and 16 of the Act.

Findings of Fact and Conclusions of Law

The Commission modifies the Arbitrator's Decision as follows:

Findings of Fact:

The Commission strikes the second paragraph on page three through the last paragraph on page four which continues on the top of page five, and substitutes the following:

On the day of trial, Petitioner made an oral motion to amend his Application for Adjustment of Claim to change the date of accident from January 26, 2013 to January 29, 2013 and the motion was granted over Respondent's objection. (R 7) When asked on cross-examination if the document he signed as Exhibit No. 1 was incorrect, Petitioner replied "That was a typo." (R 79) When asked "if all these records have January 26th multiple times throughout them, those are all typos too?" Petitioner replied "I was clearly saying the 29th." When asked if the doctors would have been wrong if they were attributing his injury to an accident on the 26th, Petitioner testified he did not know. (R 79)

Prior to January 2013, Petitioner testified that he had been treating for a stomach condition and had surgery called a Nissen Fundoplication on December 19, 2012. (R 15) Petitioner testified he also had GERD (gastrointestinal reflux disease) and ulcers in the stomach lining and reaching his esophagus. (R, 15, 16) He also testified that he treated for various stomach issues for about three years prior to 2012 due to ulcers and GERD. (R 72) He originally sought treatment with different gastroenterologists including one from Hinsdale Hospital, one from MacNeal Hospital and one from Resurrection Health Care. (R 71) Petitioner testified that after his condition worsened, he eventually sought treatment with Dr. Bruce Dillon. (R 73) Dr. Dillon eventually performed the surgery. (PX 14) Petitioner testified the surgery fixes hiatal hernias where the stomach gets pushed up to the diaphragm of the chest wall. (R 15)

Petitioner had a post-operative visit with Dr. Dillon on January 3, 2013. Dr. Dillon's office note documents Petitioner reported having returned to the ER after surgery and was discharged Christmas eve, although Dr. Dillon was not aware of this. (Px10). By January 3, 2013 he reported he was tolerating a mechanical soft diet with minimal dysphagia. He was not having any regurgitation as he had preoperatively. He intended to return to work the following Monday. (PX10)

On the day he returned to work for Respondent, January 7, 2013, Petitioner went to the Emergency Room (ER) at Elmhurst Memorial Hospital in the evening. (R 17, 75) On cross-examination, Petitioner was asked whether he was seeking treatment on that day because the surgery was not working and he replied "no" but he was feeling discomfort in his esophagus and "when I tried to advance my diet from a clear to a soft food diet, there was food going slowly down my passage way." (R 76) The Elmhurst records were not submitted into evidence, however, Dr. Dillon's office visit on January 31, 2013 documents Petitioner went to the ER on January 7, 2013 for symptoms of severe dysphagia, and underwent an EGD (upper endoscopy) which "reportedly demonstrates no esophagitis and an intact fundoplication without evidence of hiatal hernia." (PX10)

Petitioner was thereafter working full-duty. He testified on Tuesday, January 29, 2013 he was back in the shipping and receiving department assisting. At the end of the day, to load a truck, A Motorola shipment, the truck backed into dock. Petitioner testified "We pulled the dock plate, loaded multiple skids on an incline into the truck to the back of the truck where I ended up pushing the pallet jack with all my force to get the weight of the pallet to the front of the truck. And I felt a pop and sharp stabbing pain along with nausea." (R, pp. 18, 19) A picture of the dock where the truck backed up was admitted into evidence. (PX 2)

Petitioner testified he was using the pallet jack. He described how to use that manually, "load the pallet jack underneath the skid. Use the handle to pump the handle to raise it to a certain level where you could move the skid without dragging or restrictions on the floor. Then you use your legs and upper body to use force to push up a ramp, the dock plate into the back of the truck." (R, 21, 22)

Petitioner testified he reported it to his employer the next day "in the morning time." He did not report it that day because it was at the end of the shift. His boss had meetings in the afternoon. Petitioner testified his direct boss was Scott Andrews. (R 22) He testified he told Scott Andrews as soon as he got in for the day. He testified that Andrews got in around 7:45 to 8:15 in the morning, approximately. He let him settle in at his desk before he went into the front office. The conversation happened in his office. Petitioner testified he told Andrews the event that happened at the end of the shift the previous day. "I was loading a skid onto a truck and felt a pop and sharp stabbing pain in my chest after it happened." (R 23) I told him I was going to contact the doctor, the surgeon, Dr. Dillon, to go in for an evaluation. (R, 23, 24)

Petitioner did not recall anyone ever asking him to put something in writing or to fill out anything in writing. (R 24) He made the appointment with his doctor and told him "I was loading a few skids from a shipment of Motorola onto a truck at the end of my shift. When I was pushing the pallet using the pallet jack on an incline into the back of the truck, I used all of my weight to get it back there, in which I felt a pop, sharp, stabbing pain in the top of my chest. I told him it happened on Tuesday." (R 24, 25)

Petitioner sought treatment for the first time-two days later-with Dr. Dillon on January 31, 2013. (R 24, PX 10) Petitioner testified he told Dr. Dillon what happened at work and he felt a pop and sharp stabbing pain. (R 24) Dr. Dillon's January 31, 2013 office note states "At work on Tuesday, now 48 hours ago, while moving a palate (sic) of materials by himself (1300 pounds?), he developed acute substernal chest pain and now has recurrent reflux symptoms-heartburn." (PX 10) Dr. Dillon recommended further testing, including a barium swallow tests which Petitioner underwent. (PX 10, R 26) Ultimately, Dr. Dillon could not find the source of Petitioner's complaints having received results of an upper GI test underwent by Petitioner on February 1, 2013 that showed no evidence of hiatal hernia or reflux. (PX 10) Dr. Dillon referred Petitioner to Dr. Nathaniel Soper, in the department of surgery at Northwestern. (PX10)

Prior to seeing Dr. Soper, Petitioner sought treatment with his family doctor, Dr. Shaikh-Abbasi. (R 27) On February 7, 2013 Dr. Shaikh-Abbasi's History of Present Illness (HPI) stated "Was referred to Dr. Lee for persistent reflux-Had Nissens fundoplication 12/19/12 by Dr. Bruce Dillon @Advocate Good Samaritan hospital-Had endoscopy 1/2013 and was looking clear-However for the last week or so, he has developed recurrent symptoms with chest pain. Had barium swallow 2/1/13 which seemed normal. Chest pain mid sternal since prior to the barium surgery-Still with increased chest pain-He called the surgeon and GI and has been told that his symptoms are not from GI—Has been on Protonix twice a day since his surgery." Petitioner was given prescriptions for Protonix and Zantac. (PX 11, p. 1)

Petitioner first saw Dr. Ikuo Hirano at Northwestern on April 9, 2013 before being able to see Dr. Soper. (R 28) Dr. Hirano noted he was at work approximately one month after his fundiplication surgery and perhaps after doing some lifting at work, developed re-current symptoms and intensified chest pain. Dr. Hirano recommended an EGD, HRM and UGI. (PX 12, pp. 3-4)

Petitioner testified he underwent these tests performed at Northwestern Hospital. (PX 13) Ultimately, Petitioner saw Dr. Soper for the first time at Northwestern on June 7, 2013. Dr. Soper's history documents Petitioner underwent Nissen fundoplication last December. Things went well for the first six weeks, at which point he was lifting a heavy object experienced severe chest pain and nearly continuously since then. (PX 12, p. 82) Dr. Soper's impression was that Petitioner "has atypical chest pain of unclear etiology, occurring following a Nissen fundoplication. Thus far, with extensive evaluation, there is no obvious etiology." He recommended additional testing, including a pH impedance test that was normal. (PX12, pp. 83,

93) Ultimately, after these tests, Dr. Soper agreed to perform a redo fundoplication surgery on July 2, 2013. (PX 12, p. 94)

The Commission also strikes the entire section "Arbitrator's Conclusions of Law" beginning with the second paragraph on page eight through page 15 and substitutes the following:

Causation

Pre-accident treatment: Petitioner testified prior to the accident he had been treating for a stomach condition and had surgery called a Nissen Fundoplication on December 19, 2012 to fix a hiatal hernia in his stomach. Petitioner testified he treated for various stomach issues for approximately three years prior to the 2012 surgery for ulcers and gastrointestinal reflux disease (GERD) with multiple doctors prior to the one he decided upon to do his surgery-Dr. Bruce Dillon.

The Petitioner's symptoms prior to and after the work-related accident involve the same body parts, thus review of his treatment immediately before the incident is necessary to the issues at bar.

The medical records from Adventist LaGrange Memorial Hospital confirm Petitioner was seen at the emergency room (ER) on March 20, 2012, several months before his Nissen Fundoplication surgery. It was noted he had treated for several weeks for severe GERD and esophagitis at that time. He reported he was admitted to a hospital for chest pain two weeks prior. His chest pain was thought to be GI related. He reported the chest pain continued and had not gotten better. (Rx6, p. 260) The same records confirm Petitioner reported a pre-accident history of tachyarrhythmia since he was 15 years old. (Rx6, pp. 318, 329)

Petitioner was again admitted to the ER at Adventist LaGrange Memorial Hospital on September 30, 2012. He had a Bravo procedure performed a few days prior to this admission at Resurrection Hospital and he had a Ph-esophogeal monitor placed at the distal esophagus. Petitioner reported prior to admission he had worsening reflux symptoms, some dysphagia and odynophagia and diarrhea. He had a CT of his chest, abdomen and pelvis. The CT history states "chest pain after endoscopy." There was evidence on CT of mild colitis and a foreign body in the esophagus, representing a latrogenically administered endoscopy capsule or pressure monitor. (Rx6, pp. 77, 88, 102-103, 111)

His history, verified in Dr. Dillon's November 6, 2012 pre-accident history of present illness (HPI), states: "...three-year history of significant gastroesophageal reflux and heartburn. Over the last 2 years she (sic) has had 3 upper GI endoscopies all of which have demonstrated esophagitis. He is (sic) been treated with a variety of antacids including both H2 blockers & proton pump inhibitors. He is currently on Carafate and Zederid. He is also using a GI cocktail consisting of 2% lidocaine, liquid Benadryl and Maalox every few hours for symptomatic relief. He underwent a "Bravo" pH study in September at Resurrection Hospital. We will attempt to obtain those results. He has also undergone recent CT scan of the chest and abdomen and barium upper

GI at LaGrange hospital… He has been given a referral for esophageal manometry but was told at Northwestern University this could not be performed before March 2013. He is referred today for consideration/discussion about fundoplication." (Px10)

The December 4, 2012 office note confirms Dr. Dillon and Petitioner decided to proceed with the Nissen fundoplication. Dr. Dillon's notes confirm they reviewed expectations of his perioperative hospital stay, postoperative recovery and convalescence and noted Petitioner "understood this is a physiologic procedure which falls short of perfection but offers very good and durable control of gastroesophageal reflux." It was also noted he understood the *long-term changes he needed to make in his lifestyle and in his eating habits if he is to maximize his result.* He also understood *the possibility his reflux would persist* and *that additional surgery could be required in the future.*" (Px10) (emphasis added)

After Petitioner underwent laparoscopic Nissen fundoplication surgery on December 19, 2012 at Good Samaritan Hospital, he was readmitted for dysphagia on December 24, 2012. Those records were included with those from Northwestern Medical Group. The HPI states: "…with increasing problems swallowing solids and liquids over the past 16 hours. …States that he feels that 10% of his food has been coming back up, and he has to 'wait to re-swallow it.'" (Px12, pp. 14-20)

He saw Dr. Dillon January 3, 2013. He reported tolerating a mechanical soft diet with minimal dysphagia. He was not having any regurgitation as he had preoperatively. He reported he intended to return to work the following Monday. (Px10)

The regurgitation that was not as severe as preoperatively, was also increasing as evidenced by Petitioner's second trip to the ER on January 7, 2013. Petitioner presented to the ER at Elmhurst Hospital on January 7, 2013 with complaints of severe dysphagia. He was seen in consultation there by Dr. Patrick Lynch and underwent an EGD (Esophagogastroduodenoscopy or upper GIendoscopy) which demonstrated no esophagitis and an intact fundoplication without evidence of hiatal hernia. (Px10, 1/31/13) Petitioner testified this was the same date he had returned to work. (T, p. 17) Thus, Petitioner was having problems after the first Nissen fundoplication surgery that prompted two ER visits with an admission of severe dysphagia by January 7, 2013.

Petitioner testified there was no issue (found) when he went to the ER on January 7, 2013. The wrap was intact, no signs of any hernias. (T, p. 18) The Elmhurst Hospital records were not offered into evidence. The Commission finds the fact Petitioner sought treatment at the ER twice, and upon admission he had severe dysphagia that required EGD testing, are evidence that he was already having recurrent symptoms. Prior to surgery, on December 4, 2012 Dr. Dillon reviewed with Petitioner the risks of the surgery and "the possibility his reflux would persist and that additional surgery could be required in the future."

Post-accident: When Petitioner returned to Dr. Dillon on January 31, 2013 he reported he was at work Tuesday, 48 hours prior, while moving a palate (sic) of materials he developed acute

substernal chest pain and now has recurrent reflux symptoms-heartburn. (Px10) Petitioner testified on January 29, 2013 he was in the shipping receiving department assisting. "At the end of the day (to) load a truck...the truck backed into dock. We pulled the dock plate, loaded multiple skids on an incline into the truck to the back of the truck where I ended up pushing the pallet jack with all my force to get the weight of the pallet to the front of the truck. And I felt a pop and sharp stabbing pain along with nausea." When asked where he felt the pain, Petitioner responded, "in the chest." "Near the upper portion of the stomach and the lower portion of the stomach and the lower portion of the esophagus." (T, pp. 18-19)

Petitioner also testified when he first saw Dr. Dillon he told him: "I was loading a few skids from a shipment of Motorola onto a truck at the end of my shift. When I was pushing the pallet using the pallet jack on an incline into the back of the truck, I used all of my weight to get it back there, in which I felt a pop, sharp, stabbing pain in the top of my chest."

The Commission finds the Petitioner's testimony contains much more detail with respect to the accident than the initial medical records, or any medical records introduced into evidence. While Petitioner testified he moved a pallet, the medical records contain no specific details that match the Petitioner's testimony regarding "forceful pushing" and specifically there is no mention of a "pop" or feelings of nausea in the initial, or any, medical history that comport with Petitioner's testimony.

An upper GI test was performed on February 1, 2013. The Impression from that double contrast upper GI with barium swallow stated: "Post Nissen fundoplication without evidence of mass or ulceration. Duodenal bulb and sweep are normal. No stricture, mass or ulcer." (Px10)

Petitioner went to his primary care physician, Dr. Shaikh-Abbasi at Family Medical Group, one week later, on February 7, 2013. (Px11) The HPI states he was referred to Dr. Lee for persistent reflux. "Had Nissen fundoplication 12/19/2012 by Dr. Bruce Dillon @Advocate Good Samaritan hospital-Had endoscopy 1/2013 and was looking clear-However for the last week or so, he has developed recurrent symptoms with chest pain. Had barium swallow February 1, 2013 which seemed normal. Chest pain midsternal since prior to the barium surgery-Still with increased chest pain-He called the surgeon and GI and has been told that his symptoms are not from GI-Has been on Protonix twice a day since his surgery."

The Commission finds of utmost significance the fact that the reported injury was not so severe it merited a trip to the ER on the day it occurred, or the day after, and was so inconsequential Petitioner never mentioned it to his PCP one week later.

The Commission finds the fact that Petitioner did not go to the ER on January 29th or 30th, or for any medical treatment, speaks volumes in the context of this Petitioner's medical history. The fact that Petitioner did not receive any medical attention on the alleged date of accident, either at the ER or elsewhere, is entirely inconsistent with the Petitioner's prior and subsequent medical diligence and countless visits to the ER.

18IWCC0347

The Commission also finds Petitioner's complaints to his PCP, Dr. Shaikh-Abbasi, and to Dr. Dillon, are consistent with his preexisting condition and cannot be related to his testimony regarding the work-related accident on January 29, 2013.

The Commission further finds the work-related accident on January 29, 2013 did not cause a change in Petitioner's condition. The Petitioner was actively treating for his condition for years and the month prior to the accident, he had the Nissen fundoplication surgery in an attempt to remedy his complaints. Petitioner had been in the ER, readmitted after the surgery and then returned to the ER a second time after his surgery for severe dysphagia, all before the work-related incident.

Further supporting the fact that Petitioner's condition was unchanged after the work-related accident, Dr. Dillon's February 21, 2013 office progress note documented the results of the tests showed no change since the first surgery and subsequent complaints: "In early January he was seen at Elmhurst hospital with a presumed impacted food bolus. He underwent an EGD at that time which was quite unremarkable. There was no evidence of esophagitis described. A follow-up conventional barium upper GI was performed earlier this month which demonstrates an anatomically intact fundoplication with evidence of reflux or hiatal hernia. He is considering today takedown-reversal of his fundoplication. The Impression section states: pharyngeal esophageal dysphagia-**etiology(?).** Apparently intact and normal functioning Nissen fundoplication." (emphasis added) (Px10)

The Commission finds the EGD done at Elmhurst hospital and the follow-up barium upper GI test confirm no additional insult or injury occurred as a result of the reported work-related injury. Dr. Dillon, at a loss to explain his ongoing complaints, referred Petitioner to Dr. Nathaniel Soper at Northwestern Medical Group. (Px10)

On April 9, 2013, Petitioner presented to Northwestern Medical Center. The Petitioner signed the patient intake form listing the reason for the referral as" Post Nissen Fundoplication Complications" without reference to any work-related incident. Petitioner first saw Dr. Hirano and a GI Office Note recounted Petitioner's medical and GI history..." Underwent lap Nissen fundoplication 12/19/12 by Dr. Dillon at Good Samaritan. Had relief of symptoms for about a month post op but was also kept on a liquid diet for several weeks post-op. About a month later, *perhaps* after doing some lifting at work, developed recurrent symptoms that are even worse than what he experienced pre-op. Clearly feels that chest pain has intensified in severity and frequency since surgery." (Px12, p. 3) (emphasis added)

The Commission notes the history given to Dr. Hirano does not comport with Petitioner's testimony. There was no history that Petitioner felt a "pop" or immediate onset of nausea nor did Petitioner provide details remotely matching the description given at trial of forceful pushing a heavy pallet.

Dr. Hirano went on to address causation: "It is unclear at this time whether the patient has an etiology for his chest pain other than GERD to explain the lack of preop response to PPI and lack of response to the fundoplication. *Etiologies here include esophageal dysmotility, functional chest pain, eosinophilia esophagitis. The other possibility is that his fundoplication has now failed or lead to a paraoesophageal hernia or sub diaphragmatic pain syndrome.* (Px12, p. 4) (emphasis added)

Dr. Soper's June 7, 2013 clinical notes document: "My impression is that he has atypical chest pain of unclear etiology, occurring following a Nissen fundoplication. Thus far, with extensive evaluation, *there is no obvious etiology*." (Px12, p. 88) (emphasis added) The Commission also notes Dr. Soper's notes document it was Petitioner who pushed for the second surgery. On June 28, 2013, Dr. Soper wrote "He is extremely intent upon operative treatment." (Px12, pp. 93, 94) "The patient was insistent on proceeding with reoperation despite the inability to guarantee that repair of the hernia would improve his pain." (Px12, 5/13/14 letter)

On July 8, 2013 Petitioner saw Dr. Shaikh-Abbasi for follow-up after his redo Nissen fundoplication surgery at Northwestern. Petitioner was found to be tachycardic with HR of 160-200 post surgery. He was in the hospital overnight. The Commission finds the Petitioner's various chest pain complaints were pre-existing and ongoing. Petitioner reported chest pain at his earlier hospitalizations on September 22, 2012, September 30, 2012 and October 27, 2012. (Rx6) Furthermore, his chest pain symptoms were complicated by a pre-existing and ongoing tachycardic heart condition since he was 15 years old.

On December 10, 2013, the Petitioner saw Dr. Hirano at Northwestern Medical Group. He reported he "did well post op for the first four months except mild dysphagia for meat. Late October 2013 he had recurrent SSCP and episodes of chest pain several times per day lasting 45 minutes to a few hours. Over the prior two weeks he was experiencing constant pain accompanied by severe post prandial nausea. Sharp lower sternal pain that radiates to the back. Severe nausea reportedly made it hard to function." He also reported intermittent upper abdominal pain. (Px12, p. 110)

On May 13, 2014, Dr. Soper authored a one-page letter to Petitioner's attorney responding to interrogatories. He wrote "Petitioner did well and was minimally symptomatic until lifting a heavy object at work on January 26, 2013." The Commission finds Dr. Soper's 2014 causation opinion is flawed. The date of accident Dr. Soper references is not consistent with the accident date Petitioner claimed at trial.

In addition, in reply to the interrogatories, Dr. Soper's causation opinion was equivocal stating: "heavy lifting leads to a Valsalva maneuver, which puts a strain on the diaphragm and *could cause* the hiatal hernia to recur." (emphasis added)

The Commission finds Dr. Soper's 2014 equivocal causation opinion was not consistent with his June 7, 2013 office notes that states "Thus far, with extensive evaluation, there is no

obvious etiology." After the second surgery, Dr. Soper's last office note dated May 29, 2015 also documents: "He has chest pain of unknown etiology. ...I am at a loss given the normal anatomic nd physiologic evaluation of his hiatal hernia repair and fundoplication." (Rx12)

Furthermore, the Commission finds Dr. Soper's opinion Petitioner was "minimally symptomatic" was flawed because he had symptoms severe enough to precipitate two post-operative visits to the ER on January 7, 2013. Both ER visits were within weeks of his first surgery. The Commission finds Dr. Soper's 2014 opinion is therefore not credible and is entitled to little weight. *See, e.g.*, Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n, 2014 IL App (3d) 130028WC, 14 N.E.3d 16, 383 Ill. Dec. 184 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

On June 17, 2014 Petitioner went to the ER at Northwestern Memorial HealthCare again for chest pain. He reported multiple men in his family with early CHR, arrhythmia. The Patient had a recent Holter but was uncertain of results. The chest pain was diagnosed as likely secondary to GERD. The Addendum stated: "Reassuring EKG and recent echo. Trop negative. Suspect severe GERD as etiology of symptoms. Symptoms similar to prior GERD flares and have been building over the last few weeks. If workup negative in ER, plan for outpatient follow-up and supportive care." (Px13, pp. 14/48, 16/48)

The subsequent redo Nissen fundoplication pre- and post-operative diagnosis was listed as "failed Nissen fundoplication" and was silent regarding a work-related accident.

Petitioner continued to have the same symptoms thereafter reporting to the nutritionist Bethany Doerfler on September 11, 2014 "he avoids eating all morning but drinks approximately one gallon of Gatorade throughout the day. He often is extremely hungry at lunch time and goes out to eat (mostly fast food) with friends at work and often orders fried foods and over eats. He then feels sick and will drink approximately 32 ounces (of) Gatorade to wash it through." (PX12)

The Commission finds the Petitioner's referenced dietary habits described by the nutritionist are at odds with the warning given to him by Dr. Dillon on December 4, 2012. Dr. Dillon's notes confirmed Petitioner "understood this is a physiologic procedure which falls short of perfection but offers very good and durable control of gastroesophageal reflux. *It was also noted he understood the long-term changes he needed to make in his lifestyle and in his eating habits if he is to maximize his result.*" (Px10) (emphasis added) The Commission places special significance on Dr. Dillon's admonishment on December 4, 2012 regarding life-style changes and Petitioner's failure to do so. The DuPage Medical records contain Petitioner's visit to Heart Rhythm Management of Lake County on April 30, 2014. At that time, that Petitioner reported his alcohol/beer intake was daily. (PX10)

The Commission is not persuaded either by Dr. Mosier's equivocal opinion given he is not a gastrointestinal specialist. Dr. Mosier also pointed out there was no evidence of the pathology described in the second operative report after a rather exhaustive diagnostic workup. (PX15, RX7)

On May 11, 2015, Dr. Hirano (Northwestern) recounted treatment to date. His Impression states: "Relapsing chest and epigastric pain and nausea post redo-Nissen fundoplication 7/13. Symptoms improved over past several months but now increased substantially after probable gastroenteritis 3/31/15. *Etiologies here similar to prior to redo include functional chest pain, post fundoplication pain syndrome.* He states he had no symptoms for the first 4 months after redo surgery. Symptoms pre-redo were similar to what he was experiencing preoperatively." (Px12) (emphasis added) Dr. Hirano never attributed the "etiology" of Petitioner's condition to a work-accident. Petitioner also testified the chest pain he began experiencing after the (second) surgery was different than the chest pain before the (second) surgery, a fact that is inconsistent with Dr. Hirano's May 11, 2015 office notes.

The Commission also notes Dr. Arora's HPI dictated on December 10, 2015 recounts the Petitioner's symptoms improved for a few weeks following the first fundoplication surgery, and "after lifting heavy boxes and pallets, his symptoms came back and he had had more pain symptoms." The Commission finds Petitioner's failure to give Dr. Arora a history of either post-surgical/pre-accident ER visits, or the EGD test on January 7, 2013, mere weeks before the work-related accident, renders this history unreliable.

Therefore, the Commission finds Dr. Arora's causation opinion is also entitled to little weight. *See, e.g.*, Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n, 2014 IL App (3d) 130028WC, 14 N.E.3d 16, 383 Ill. Dec. 184 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

Finally, the May 19, 2016 Mayo Clinic records note Petitioner reported a history of anxiety and obsessive-compulsive disorder (OCD) as a child. (Px14) The Commission finds the Petitioner's history confirms some pre-existing conditions, and a multitude of situational stressors, were the topics of his psychological sessions and resultant need for ongoing therapy. (Px14)

For all the afore-referenced reasons, the Arbitrator's Decision regarding causal connection is hereby reversed.

Notice

The Commission also finds Petitioner failed to provide Notice as provided in section 6(c) of the Act. The Commission views the evidence and Petitioner's testimony different than the Arbitrator. The Commission finds Petitioner did not timely report the accident.

Petitioner testified he had one prior workers' compensation case filed against a former employer. (T, p. 78) He testified he was a supervisor and acknowledged he received a copy of Respondent's handbook when he began employment with Respondent. The Commission infers that Petitioner would thus be familiar with reporting requirements. In this case, however, the human resource manager, Michelle Sutton, testified the first time she became aware Petitioner was filing a Worker's Compensation claim was in early September 2013 when she received the

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Application for Adjustment of Claim in the mail. (T, p. 104) Sutton testified as part of employee orientation "how to report an accident" or the "importance of reporting an accident" is covered. The Respondent also had two signs or posters displaying the way to report an injury. (T, pp. 107, 108)

In addition, Sutton testified not one of Petitioner's three co-workers recalled that Petitioner ever reported a work accident. (T, p. 105) Petitioner claimed to be injured, underwent surgery as stated above and Respondent had no knowledge of the injury.

Petitioner testified he told his direct supervisor, Scott Andrews the day after the incident occurred, however, did not recall being asked to fill out paperwork. (T, pp. 22, 23) Scott Andrews testified he did not recall ever being told about a work-related accident. (T, pp. 90, 101) Petitioner offered no reason for failing to request the necessary paperwork to report the incident or for not ever communicating with human resources prior to filing his Application for Adjustment of Claim nine months later. Thus, the Commission finds Sutton and Andrews were more credible witnesses than Petitioner regarding the Notice issue.

The purpose of the notice requirement is to enable the employer to investigate the employee's alleged industrial accident. *Seiber v. Industrial Comm'n*, 82 Ill. 2d 87, 411 N.E.2d 249, 44 Ill. Dec. 280 (1980). *White v. Workers' Comp. Comm'n*, 374 Ill. App. 3d 907, 910-911, 873 N.E.2d 388, 391, 313 Ill. Dec. 764, 767. Petitioner's actions prevented Respondent from obtaining an independent medical examination prior to his second surgery, an opinion that did not rely entirely upon Petitioner's history, thus the Respondent was prejudiced.

For all the afore-referenced reasons, the Arbitrator's Decision regarding Notice is hereby reversed. Based upon its prior finding regarding causal connection, the Commission would still deny said claim, even if appropriate Notice was given.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 12, 2016, is hereby affirmed regarding accident, reversed regarding causal connection and notice and modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 12, 2016 is vacated with respect to Notice.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 12, 2016 is vacated with respect to causal connection.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award under §8(a) of the Act, medical services and expenses delineated in Petitioner's Exhibits 1 through 16 is hereby vacated.

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IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award under §8(a), for prospective medical treatment in form of the rehabilitation program recommended by Dr. Arora at Mayo Clinic is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION, the Arbitrator's award under §8(a) for reimbursement for mileage to/from Petitioner's home to/from Mayo clinic is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Arbitrator's award of penalties and attorneys' fees under Sections 19(k), 19(l) and 16 is hereby vacated.

This award in no instance shall be a bar to a further hearing and of compensation for permanent disability, if any.

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

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

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

"The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission." The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 4 – 2018
KWL/bsd
O: 04/03/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

SPAYER, STEVEN
Employee/Petitioner

Case# **13WC028581**

NETCOM INC
Employer/Respondent

18IWCC0347

On 8/12/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2998 MARKER & ASSOCIATES PC
JASON A MARKER
4015 PLAINFIELD-NAPERVILLE RD
NAPERVILLE, IL 60564

2837 LAW OFFICES JOSEPH A MARCINIAK
TWO N LASALLE ST
SUITE 2510
CHICAGO, IL 60602

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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)

Steven Spayer
Employee/Petitioner

v.

Netcom, Inc.
Employer/Respondent

Case # **13** WC **28581**

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 **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **6/16/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **1/29/13**, 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 **$20,596.24**; the average weekly wage was **$735.58**.

On the date of accident, Petitioner was **26** years of age, ***single*** with **1** dependent child.

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

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

Respondent is entitled to a credit under section 8(j of the Act for any amounts paid under its health insurance plan.

ORDER

Respondent shall pay reasonable and necessary medical services as delineated in Petitioner's Exhibits 1 through 16 within the confines of Sections 8(a) and 8.2 of the Act. Respondent shall further pay for the rehabilitation program recommended by Dr. Arora at Mayo Clinic within the confines of Section 8(a) and 8.2 of the Act, as the treatment is reasonably prescribed to treat the medical condition related to the injury herein.

Respondent shall be given a credit for any medical benefits that have been paid by the Respondent's group health insurance carrier, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Respondent shall not receive credit for any medical benefits paid for by Petitioner's later employer's health insurance.

Respondent shall pay to Petitioner penalties as provided in Section 16 of the Act amounting to 20% of the amounts awarded for outstanding medical per the fee schedule; 50% of the amounts awarded for outstanding medical per the fee schedule as provided in Section 19(k) of the Act; and **$10,000.00**, as provided in Section 19(l) of the Act.

Respondent shall pay to Petitioner reimbursement for mileage to/from his home to Mayo Clinic in the amount of $4,004.77.

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

08-11-16
Date

ICArbDec19(b)

AUG 12 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Steven Spayer,
Employee/Petitioner,

v.

Netcom, Inc.,
Employer/Respondent.

Case # 13 WC 28581

FINDINGS OF FACT

Petitioner, a 26 year old single male with one dependent (Arb 1) was working for Respondent as a materials production control supervisor. He had started working for them in June of 2012. (R 13). Petitioner described his job duties were to oversee that all shipments got out of the door on time, were packaged correctly, and that all materials were delivered to the floor for proper assembly. (R 14). He stated he was responsible for supervising two employees – Frank in shipping and Norma in the materials cage. (R 13-14). He noted Respondent had an account with Motorola and would ship antennae for government military devices. (R 14). Petitioner testified that it was part of his job duties to directly help pack and ship out, on top of loading and unloading trucks that would come in. (R 14). He stated he would have to help load or unload about two or three times a week. (R 15).

Prior to January of 2013, Petitioner testified that he had been treating for a stomach condition and had a surgery called a Nissen Fundoplication on December 19, 2012. (R 15). This was a surgery to fix a hiatal hernia in his stomach. (R 15). He testified that he treated for various stomach issues for about three years prior to 2012 due to ulcers and GERD (gastrointestinal reflux disease. (R 72). He originally sought treatment with a gastroenterologist out of Hinsdale Hospital, one from MacNeal Hospital, and one from Resurrection Health Care. (R 71). Petitioner testified that after his condition had gotten worse, he eventually sought treatment with Dr. Bruce Dillon, whom recommended and performed the fundoplication surgery on December 4, 2012. (R 73). A fundoplication surgery, as per Dr. Dillon's operative report, is where the patient's upper stomach (fundis) is tied around his esophagus in order to eliminate the hernia. (PX 14).

Petitioner testified that after his surgery, he was released to return back to work by Dr. Dillon as of December 31, 2011, but his son was born on that day, and so; he was given a week extension and returned to work officially on January 7, 2013. (R 17). Petitioner had a post-operative visit with Dr. Dillon on January 7, 2013, which was the very same day he returned to work for Respondent. (R 17). He saw Dr. Dillon that same evening at Elmhurst Hospital. (R 17). On cross exam, Petitioner was asked whether he was seeking treatment with Dr. Dillon on that day because the surgery was not working, and he stated, that was not true. (R 76). Rather, Petitioner described that he was feeling discomfort due to advancing his food diet from clear to soft foods and he was having discomfort in his esophagus. (R 76). When he saw Dr. Dillon at the Hospital on January 7, 2013, an upper endoscopy was performed which revealed the wrap was normal and Petitioner was given a clear release to return to work full duty. (R 17 & PX 10).

Petitioner was thereafter working full duty and testified that on Tuesday, January 29, 2013 (nearly three weeks later), he was back in the shipping and receiving department assisting at the end of the day to load a Motorola shipment into a truck that had backed into the dock. (R 18-19). He stated this occurred near the end of his shift

that day. (R 19). The truck backed into the dock, and he pulled the dock plate onto the truck and loaded multiple skids with a pallet jack up an incline into the truck. (R 19). He testified that he ended up pushing the pallet jack with all of his force to get the weight of the pallet to the front of the truck and he felt a pop and sharp stabbing pain in his chest along with nausea. (R 19). A picture of the dock where the truck backed up to was admitted into evidence. (PX 2). The Abitrator notes that even when a truck is backed completely up to this dock, the truck bed would be at an include as there is no flat leveled-off drive underneath the truck at its point closest to the dock/building. (PX 2). Petitioner described how he would have to manually load the pallet jack underneath the skid by using a handle to pump and raise it to a certain level when he could move the skid, after which; he would have to use his legs and upper body with force to push it up a ramp, over the dock plate and up into the back of the truck. (R 22).

Petitioner testified he reported the incident to his employer, specifically Mr. Scott Andrews, the next morning. (R 22). He did not report it that day because it occurred near the end of his shift and his boss, Mr. Andrews, was in meetings all day. (R 22). Petitioner stated that the next morning, he waited for Mr. Andrews to get into work, which was normally about 7:45 to 8:15. (R 23). He let him settle in at his desk in his office and then went into his office and had a conversation that morning with Mr. Andrews. Petitioner testified he told Mr. Andrews what had happened the previous day – that he was loading a skid onto a truck and felt a pop and sharp stabbing pain in his chest, and that he was going to contact his doctor for an evaluation. (R 23). Petitioner did not recall being asked to put anything in writing. (R 24).

On the day of trial, Petitioner made an oral motion to amend his Application for Adjustment of Claim to change the date of accident from January 26, 2013 to January 29, 2013 and the motion was granted over Respondent's objection. (R 7). On cross examination, counsel for Respondent asked Petitioner whether he was claiming for the first time ever at hearing that his injury occurred on January 29, and petitioner stated "no". (R 79). When asked if the doctors would have been wrong if they were attributing his injury to an accident on the 26th, Petitioner stated he did not know, but was clearly saying the 29th. (R 79).

Petitioner sought medical treatment for the first time – two days later - with Dr. Dillon on January 31, 2013. (R 24 & PX 10). Petitioner testified he told Dr. Dillon what happened at work and that he felt a pop and sharp stabbing pain. (R 24-25). Medical records from Dr. Dillon on the same date confirm same and indicate, "at work on Tuesday (January 29), now 48 hours ago, while moving a pallet of materials by himself (1300 pounds?), he developed acute substernal chest pain and now has recurrent reflux symptoms – heartburn". (PX 10). Dr. Dillon recommended further testing, including a barium swallow test, which petitioner underwent. (PX 10 and R 26). Ultimately, Dr. Dillon could not find the source of Petitioner's complaints, and he referred Petitioner to Dr. Nathaniel Soper, who is a gastroenterologist specialist at Northwestern Hospital in Chicago, IL. (P 27).

Prior to seeing Dr. Soper, Petitioner sought treatment with his family doctor, Dr. Shaikh-Abassi, because he could not get into see Dr. Soper for two or three months. (R 27). On February 7, 2013, records show Dr. Abassi persecuted medications for Petitioner including Protonix and Zantac. (R. 28 and PX 11, P.1). Petitioner took the medications and then first saw Dr. Ikuo Hirano at Northwestern on April 9, 2013 before being able to see Dr. Soper. (R. 28). Notes from Dr. Hirano on that day indicate a consistent history of injury, noting that he was at work about a month after his fundoplication and was doing lifting and developed recurrent symptoms and intensified chest pain. Dr. Hirano recommended an EGD, HRM and UGI. (PX 12, P.3-4).

Petitioner testified he underwent these tests and they were all performed at Northwestern Hospital. (PX 13). Ultimately, Petitioner saw Dr. Soper for the first time at Northwestern on June 7, 2013. His records noted a consistent history including his lifting heavy objects about six weeks postoperatively and feeling increased chest pain nearly continuously since then. (PX 12, P. 82). Dr. Soper noted there was a suggestion of a small hiatal

hernia after reviewing test results, but he recommended additional testing, including biopsy of the esophagus and a manometry test. (PX 12, P.83). Petitioner testified Dr. Soper also recommended a pH study, which is where a thin wire is inserted through the nose into the stomach and remains there for 48 hours while he was to press a button whenever he felt pain or nausea. (R 31-32). Ultimately, after these tests, Petitioner testified he was told by Dr. Soper that he had a new small hiatal hernia in his wrap and surgery was recommended to repair the original fundoplication. Dr. Soper performed the surgery to repair the wrap on July 2, 2013. (R 32, PX 12).

Just prior to his surgery, Petitioner was given a letter from his employer eliminating his position, effective June 14, 2013. (R 33 & PX 3). Petitioner testified he was called into the conference room at work by Michelle Sutton and given the letter. (R 33-34). He has not worked for Respondent since that time and later found employment on his own with Dorma, USA, whom he started with in October of 2013. (R 13).

After surgery, Petitioner followed up with Dr. Soper in September 2013 and he was having pain at his incisional sites. (R 35). He was told to use warm compresses and take medications for pain. (R 35). He testified there were seven (7) incision sites from the surgery – two in his lower abdomen and five in an archway pattern at the top of his abdomen. (R 35). He testified the pain he was having was from the incision sites in the archway at the top of his abdomen. (R 35). He testified that within a few months from surgery, he began feeling more chest discomfort, which was different than the kind of pain he had before the surgery. (R 37). He testified this pain was in a different location – it spread throughout the abdomen and near his sternum/rib area – between both ribs in the center of his chest. (R 37). He underwent additional testing to determine the etiology of the pain, including an upper GI on December 13, 2013 and was told the results were normal. (R 38). Petitioner was then referred by Dr. Soper to a pain doctor at Northwestern, Dr. Nagpal. (R 38).

Petitioner saw Dr. Nagpal, the pain doctor, for the first time on January 3, 2014 (PX 12, P.114). He recommended a course of medications and lidocaine patches at the incisional site in his stomach/chest area. (R 39). Petitioner testified he would use the patches once a day every twelve hours. (R 40). He had another upper GI after being hospitalized at Northwestern in June of 2014 due to worsening chest pain, abdominal pain, dizziness and extreme nausea. (R 40). Petitioner thereafter followed up with Dr. Nagpal, who prescribed Lyrica, which Petitioner began taking. (R 41). He had another upper GI In September of 2014 and he testified the doctors were trying to figure out why he was still having the chest discomfort. (R 41). Petitioner was referred to a dietician at Northwestern, Dr. Bethany Doerfner on September 9, 2014, whom explained to him a new diet of foods and regimen he had to follow. (R 42 & PX 12).

Petitioner was hospitalized again in March of 2015 with a fever and pain in the incisional sites. (R 43 & PX 13). He thereafter followed up with Dr. Hirano on April 8, 2015 and discussed the pain in his incisional sites. (R 43). Dr. Hirano performed a procedure whereby he drained puss from one of the incisional sites and he prescribed antibiotics and warm compresses. (R 44, PX 12). Petitioner underwent another upper GI study at the recommendation of Dr. Soper on May 11, 2015 and he was told it was negative. (R 44). Dr. Soper then recommended Petitioner follow-up with a specialist at the Mayo Clinic in Rochester, Minnesota, and he provided petitioner with a referral. (R 45 & PX 12).

Petitioner's first treatment at Mayo Clinic was on July 9, 2015 at which time he saw Dr. Arora. (R 45 & PX 14). He provided a detailed summary of his history of his original fundoplication in 2012 and his incident at work lifting pallets and heavy boxes and aggravation of his symptoms. (PX 14). Dr. Arora performed an exam and diagnosed him with dyspepsia, visceral hypersensitivity, abdominal pain secondary to neuromas at his surgical sites, and dumping syndrome. (PX 14). He was given two pamphlets that day regarding his diagnosis, one was called "Dietary Guidelines for Managing Dumping Syndrome" and the other was patient education on

"Functional Dyspepsia", both of which were entered into evidence. (PX 4). Dr. Arora recommended a CT scan on that day. (PX 14)

Petitioner had the CT scan and records from Dr. Arora indicate it was OK, but that he had two fat containing incisional hernias by his umbilicus and he recommended injections into those two sites, which was performed at Mayo Clinic on July 20 2015. (PX 14). Over the next few months, Petitioner testified he underwent four rounds of injections at Mayo. (R 48). Ultimately, after injections were not alleviating his pain at the incision sites, Dr. Arora referred him to a surgeon at Mayo for a consult, Dr. Lombardo, and it was recommended the hernias at the past surgical sites be removed surgically. (R 49 and PX 14). Petitioner underwent surgery to remove them on July 28, 2015. (R 50, PX 14).

Petitioner continued to have pain in his chest/sternum area and injections were recommended by Dr. Arora, which he had on September 10 2015. (PX 14). On that day, Petitioner had a bad reaction to the injection and was admitted to the Hospital at Mayo. Thereafter, Dr. Arora recommended other procedures, including two dilations of his wrap (fundoplication). (R 51 & PX 14). Petitioner testified that the dilation of the wrap would alleviate his pain and bloating feeling. (R 52). On March 16, 2016, Petitioner underwent an ultrasound at Mayo to his chest/sternum area. (PX 14). Petitioner testified he continued to experience sharp, stabbing pains in that area, and this was the reason for the test. (R 52).

Dr. Arora later recommended a sham feed test, which Petitioner had and described this test as requiring him to eat a bacon cheese sandwich, two of them, over 35 minutes. (R 53). He stated the doctor would draw blood every five minutes to analyze enzymes associated with the vegus nerve, which is the conductor for all digestion in the body. (R 54). Petitioner testified he was told the results of the sham feed test showed that his vegus nerve was basically not active at all. (R 55).

While treating at Mayo, Dr. Arora also referred Petitioner to a dietician and a psychiatrist to develop coping strategies. (PX 14). Petitioner testified he met with both a dietician and a psychologist while treating at Mayo Clinic. (R 49). He testified he saw Dr. Cesar Gonzalez, psychologist, and the Mayo records contain summaries of those visits. (PX 14). Petitioner testified the purpose of seeing a psychiatrist was for coping with the lifestyle changes that came along with his diagnosis of the dumping syndrome and nerve damage to the vasovagal nerve. (R 56-57). At the time of hearing, petitioner testified his current medications as recommended by his doctors consisted of Protonix, Lyrica, Nortriptyline, Zofran, Compazine, Hyoscyamine Sulfate, Bentil, Metoprolo, Lidocain Patch, and Vitamin D-3. (R 57). His prescription history from CVS in 2014 and 2015 were admitted into evidence and petitioner testified he paid for all prescriptions himself, out-of-pocket. (R 58-59).

The last time Petitioner saw Dr. Arora at Mayo prior to the hearing, the doctor recommended a pain rehabilitation program. (PX 14). Petitioner testified he received a letter from Mayo on June 6, 2016 with information about the pain management program. (R 67). The letter was entered into evidence as Exhibit # 9 and the third page detailed the program being a seventeen to twenty two-day program at Mayo Clinic. (PX 9). Petitioner testified he currently had this program scheduled for September 6, 2016 and he was seeking the costs for this program as part of his continued medical care. (R 68).

Attached to his records is Dr. Arora's dictation of June 1, 2016 which indicates an opinion on causation when he states "clearly his vagus nerve is not responsive as judged by the sham feed test showing no rise in the HPP over 30 minutes from baseline despite gustatory stimulation…the cause is unclear…if he had damage after the first fundoplication, we would think that he would have symptoms then. He did not have it then. He had it after the second surgery with GI disturbance, most likely from vegal nerve dysfunction. He will require prolonged

therapy for this functional disorder that may include medications, neuromodulation therapy, as well as cognitive behavior therapy. I suspect this will go on for several years. (PX 14).

Attached to the medical records of Dr. Nathaniel Soper is also his opinion on causation and relatedness in this case. (PX 12, last page). He opined the heavy lifting that was done at work may have led to the recurrence of a hiatal hernia, especially relatively early postoperatively. He noted that lifting leads to a Valsalva maneuver, which puts a strain on the diaphragm and could cause the hiatal hernia to recur. He noted the work incident may have caused the recurrent hiatal hernia and additional diagnostic tests and long-term restrictions would be necessary. (PX 12, last page). He also opined that all of this treatment (which would include the re-do fundoplication) was reasonable and necessary.

Petitioner testified he was sent for an independent medical evaluation on October of 2014, at which time he saw Respondent's physician, Dr. Michael Mosier, who was not even a gastrointestinal specialist, but rather a general surgeon. (R 61 & RX 7). Dr. Moser opined in his report that "it seems there is likely some relation here to the current condition being related to overdoing it with heavy lifting in the relatively recent postoperative period following the first surgery...and there was an acute change with the lifting that caused acute substernal chest pain, with radiation to the back". He also noted the second operative report "would suggest that there might have been some pulling or tearing of the wrap that was the cause for this". At the time of his report, he opined that the medical care had been reasonable and necessary, that petitioner had not met MMI, and that the treatment plan was reasonable. (RX 7).

Despite the IME opinion, a denial letter was sent to Petitioner in the mail to his home address and Petitioner testified to having received this letter on June 10, 2015, more than two years after his accident. (PX 6). Petitioner testified some of the medical charges for all of his treatment was paid for by his group health insurance and the Hartford initially, but that to the extent there were any balances, he was seeking payment for any outstanding charges. (R 66 & 80).

Petitioner testified that as of the date of hearing, he was required to drive to May Clinic for treatment eleven (11) times and he described the route he would take form his home address in Franklin Park, Illinois to May Clinic in Rochester, Minnesota. (R 61-62). Petitioner introduced a Mapquest print-out of the route he would take and he testified this was the route he would take each time going to/from Mayo Clinic. (R 64). He testified this route required him to drive approximately 340 miles each way and the Mapquest exhibit confirms same showing the distance between his home and Mayo Clinic was 337.1 miles. (R 62 & PX 7). He testified he was seeking the standard IWCC mileage rate for reimbursement of this travel. (R 64-5).

Respondent called two witnesses to testify at hearing. The first was Mr. Scott Andrews, who testified he was Mr. Spayer's manager at Netcom in 2012-2013 at the time of the accident. (R 89). On direct exam, he testified that at no time was an event reported to him by Mr. Spayer. (R 90). He admitted that he came into the office between 7:45 and 8:15 each morning just as Mr. Spayer had said. (R 95). He admitted part of Petitioner's duties were to help out in shipping and receiving, including loading and unloading. (R 96). He admitted Motorola was a client who they shipped for typically on Tuesdays and Thursdays. (R 97). On cross exam, Mr. Andrews testified he hired Mr. Spayer, that he had various conversations with him about his medical condition and he knew what Mr. Spayer was going through. (R 99). He admitted it was possible that because he spoke to Mr. Spayer often about his medical condition, that if he had mentioned something to him the morning after his accident, he might not have understood it and felt he was speaking about the medical treatment he was already going through. (R 100).

Respondent called Michelle Sutton to testify at hearing as well. She testified she was the HR manager for Respondent at the time of Petitioner's accident. (R 102). She testified her first notice of any work injury was from her receipt of the filing of Petitioner's Application for Adjustment of Claim, which she would have received in early September of 2013. (R 104). She testified she conducted an investigation and interviewed various employees, none of which knew of Petitioner's injury. (R 107). She admitted that she examined attendance records and that January 26, 2013 was a Saturday and Petitioner was not on the schedule that day because "no one had been at work that day". (R 110). On cross examination, Ms. Sutton admitted she did not conduct an accident investigation until eight or nine months after the accident and that she had no way of knowing whether all of the folks she spoke to remembered things properly or not. (R 115). She agreed that if Mr. Spayer had reported the incident to Mr. Andrews within 14 hours, this would have met company policy. (R 116).

CONCLUSIONS OF LAW

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

The Arbitrator finds petitioner's injury arose out of and during the course of his employment based upon the testimony of petitioner, the other witnesses presented, and the corroborating medical records.

Petitioner, a 26 year old materials production control supervisor for Respondent, was forthright in his testimony of his pre-existing gastrointestinal condition he had been dealing with for years prior to the filing of his claim. He candidly acknowledged his past history required him to have a surgery on December 19, 2012 to fix a hiatal hernia, known as a nissen fundoplicaiton. He explained that he had this surgery while working for Respondent and his supervisor, Mr. Andrews admitted he had a good understanding of what Mr. Spayer was going through. He had been off work for some time after his surgery in December and he was released to return to work as of December 31, 2012, and would have returned but for the birth of his son on that day. He was given an additional week and returned to work on January 7, 2013. This is corroborated in Dr. Bruce Dillon's medical note of January 3, 2013.

Petitioner testified he had been advancing his diet leading up to January 7, 2013, but was having pain in his esophagus and finding this difficult, and so he presented to the Hospital the same day he returned to work – later that evening on January 7, 2013. The medical records of Dr. Bruce Dillon corroborate Petitioner's testimony. Dr. Dillon's records from January 31, 2013 indicate he was doing well at his post-operative visit of January 3, 2013 without any symptoms of heartburn or reflux and that on January 7, he presented to Elmhurst Hospital with complaints. Dr. Dillon noted petitioner underwent an EGD at the Hospital which demonstrated an intact fundoplication without evidence of any hiatal hernia. (PX 10. P.2). The evidence therefore demonstrates Petitioner's fundoplication was intact, that he had no restrictions, and was back working full duty at the time of his injury.

Petitioner testified he was back working the next three weeks without incident until his incident on January 29, 2013. He testified that on January 29, 2013, a Tuesday, he was loading the back of a truck that had pulled into the employer's doc with a shipment for Motorola. He described in detail how he was using a pallet jack that contained a load of skids up an incline and while pushing with all of his force up the incline, over the dock plate, and into the back of the truck, he felt a pop and sharp stabbing pain in his chest area and upper portion of his stomach. It is evident by viewing the picture submitted into evidence by Petitioner of the dock, that any truck

pulled all the way to the back of the dock would not be level and instead at an include while any personnel was loading trucks at that location.

The Arbitrator finds Petitioner's testimony was credible in that he was direct, forthright, and candid and that the other evidence submitted corroborates his testimony. His testimony as to his condition both before and after the incident, his accident at work, and the exact date of the accident are all consistent with the medical records. The Arbitrator finds Dr. Dillon's notes of January 31, 2013 to be most instructive. Dr. Dillon's records indicate: "at work on Tuesday, now 48 hours ago, while moving a palate of materials by himself (1300 pounds), he developed acute substernal chest pain and now has recurrent reflux symptoms – heartburn." (PX 10. P.2). The Arbitrator notes that not only is the history consistent with what Petitioner testified at trial, but the day of the accident – Tuesday – is consistent. The Arbitrator notes the history taken by an initial treating physician after a work incident tend to be the most credible, and the Arbitrator finds the history in the records weigh in favor of Petitioner's injury occurring at work on January 29, 2013 as he testified.

The Arbitrator notes Petitioner originally filed an application for adjustment of claim for a date of accident of January 26, 2013, but amended the date of accident on the application at the time of trial to January 29, 2013. With respect to Petitioner's amendment of his date of accident, the Arbitrator finds the evidence weighs in favor of Petitioner and supports his testimony. Not only is Petitioner's testimony supported by the medical records of Dr. Dillon, which indicate his injury occurred on Tuesday, January 29, 2013, but the testimony of Respondent's witnesses in this case also validate his injury occurred on that day. During her testimony, Respondent's HR representative admitted nobody was working on January 26, 2013 according to her review of attendance records because that day was a Saturday. It would have been impossible for Petitioner to have injured himself on January 26, 2013. Additionally, Mr. Andrews agreed with Petitioner that Motorola shipments were on Tuesdays, the same day the medical records indicate petitioner was injured and the same day Petitioner testified he was loading a Motorola shipment.

The Arbitrator notes the prior medical records submitted into evidence by Respondent demonstrate Petitioner was able to work at the time of his accident on January 29, 2013 and they demonstrate no other alternative explanation whatsoever for petitioner's pain. Rather, the only history contained in the records is the history of Petitioner's lifting event at work with Dr. Dillon two days later on January 31, 2013. The records do not show a patient with continued symptoms leading up to January 31, 2013 either. The Arbitrator notes Petitioner's treatment with Elmhurst Hospital on January 7, 2013, but finds Petitioner's explanation of why he sought treatment on that date is corroborated by the medical records of Dr. Dillon. He was having pain in his esophagus and merely having issues advancing his diet after surgery. There is no documentation of any pain in his chest or sternum or stomach post-surgery and prior to the records of Dr. Dillon on January 31, 2013, which specifically note the pain in his chest only began after a work related lifting of pallets 48 hours prior. Additionally, there is no documentation of any medical treatment after that point for the three weeks up to Petitioner's accident date of January 29, 2013.

The Arbitrator notes the accident investigation conducted by Respondent via HR representative Michelle Sutton did not reveal any employee had knowledge of Petitioner's accident. However, the Arbitrator does not find this testimony credible in that the accident investigation was not conducted until nine months after Petitioner's incident, and as such, the testimony is not reliable. Further, the Arbitrator notes Petitioner had already been terminated as of the date of Ms. Sutton's accident investigation, and therefore the accident investigation was self-serving and lacking. Additionally, to the extent any of her investigation revealed Petitioner had a hobby of brewing beer in kegs at home, both Ms. Sutton and Mr. Andrews testified they never heard from anybody that Mr. Spayer was ever hurt working on that hobby. As such, the Arbitrator finds this to be a red hearing.

Based upon all of the above, the Arbitrator finds the injury arose out of and during the course of petitioner's employment with Respondent on January 29, 2013.

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

The Arbitrator notes Petitioner's testimony with respect to notice of his accident is credible. Petitioner testified he waited for Mr. Andrews to come into his office the next morning on January 30, 2013 and once settled, he had a conversation with him in his office. Mr. Andrews admitted he arrived to the office between 7:45 and 8:15. Petitioner explained he told Mr. Andrews he had felt pain in his stomach pushing a load the day before and he explained he told Mr. Andrews he was going to visit his doctor to check out his condition. Petitioner testified Mr. Andrews did not ask him to complete anything in writing nor did he write down anything.

The testimony of Respondent's own witnesses was inconsistent and thus, not credible. When Ms. Sutton was asked when she conducted her accident investigation, she indicated it was not until after she received Petitioner's filed application, which would have been in September of 2013. (R 104). She testified her investigation included speaking to Mr. Andrews about the incident in question, among other employees. (R 105). Yet, when Mr. Andrews was asked on direct exam when he first became aware Mr. Spayer was claiming a work-related incident, he testified it was not until about a month prior to the hearing in June of 2016. (R 94). These two statements are so drastically opposed, that it seems difficult to image whether Mr. Sutton really spoke to Mr. Andrews or not, whether there was ever any accident investigation conducted whatsoever.

The Arbitrator also notes that although Mr. Andrews testified Petitioner never told him of a work injury, he also admitted he had a good understanding of what Mr. Spayer was going through. He admitted it was possible that Mr. Spayer mentioned his medical condition to him and that he mistook it for thinking he was treating for his prior condition rather than associating it with an aggravation of his condition due to a work injury. When asked on direct exam whether Petitioner related a work-related incident, he testified "he was talking about discomfort from his surgery". (R 91). The overall picture the testimony presents demonstrates Mr. Andrews knew what Petitioner was going through. It is reasonable to conclude that Mr. Andrews did not appreciate whether there was a work event that aggravated Petitioner's condition or not given the way it was presented to him.

The Arbitrator notes the testimony of Respondent's HR representative, Michelle Sutton, who testified she was never notified of any injury and that she conducted an investigation after receiving notice via Petitioner's Application and found no other witnesses had any knowledge of the accident. The fact that there was no accident investigation conducted by Respondent's HR representative for nine months after the accident and not until Mr. Spayer had already been terminated from his position, calls into questions the veracity and credibility of those witnesses and the investigation itself.

Overall, the Arbitrator finds Petitioner's testimony with respect to notice more credible than Respondent's witnesses. The medical records corroborate Petitioner's testimony that he had a work incident on Tuesday, January 29, 2013. Petitioner testified he notified Mr. Andrews the next day on January 30, 2013 that he was going to go to his doctor to get it checked out and the medical records indicate the very next day he saw Dr. Dillon and complained of pushing pallets at work which caused him pain in his chest area on January 29, 2013. Petitioner's testimony is consistent with the histories contained in the medical records and consistent with the time-line as he testified.

The Arbitrator therefore finds Petitioner gave timely notice of his injury to Respondent.

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

The evidence presented demonstrates Petitioner aggravated his original fundoplication and sustained a new hiatal hernia while lifting and pushing a heavy pallet of materials for his employer on January 29, 2013.

Petitioner testified he felt a pop and pain in his chest/upper stomach area immediately as he was pushing the pallet with all his might to get the load into the back of the truck on January 20, 2013. He reported this pain in the same manner to Dr. Dillon only 2 days later on January 31, 2013. Dr. Dillon's medical records corroborate his increase in pain after the event. There are no medical records that demonstrate Petitioner had this type of pain in his chest/sternum area before this date. Each doctor in this case reviewed the medical records and they all noted he was pain free while working prior to January 31, 2013 and that his pain started only after the lifting/pushing event at work. The fact that Petitioner went to a doctor on January 7, 2013 due to pain in his esophagus from advancing his diet and eating new foods is not the same pain whatsoever nor even in the same area of the body as what he experienced after the event on January 31, 2013.

The Arbitrator finds all expert witnesses in this case have opined that the event of pushing a heavy pallet at work so soon postoperatively from his original fundoplication, was likely a cause of Petitioner's recurrent hiatal hernia and need for a fundoplication repair. Dr. Nathanial Soper opined the events of pushing heavy items so soon postoperatively may have caused the hiatal hernia. Similarly, and most notably, Respondent's own IME physician, Dr. Mosier, admitted that it seemed there was likely some relation here to the current condition being related to overdoing it with heavy lifting in the relatively recent postoperative period following the first surgery.

The Arbitrator notes the cause of Petitioner's failed vegal nerve also seems to have been caused by the second redo-fundoplication performed by Dr. Soper and hence, was work related. Petitioner testified the pain in his sternum after the second fundoplication was different form the pain he had in his chest after the work incident. Both Dr. Soper and Dr. Mosier opined a second re-do fundoplication was reasonable and necessary. Only after finally going to Mayo Clinic did Dr. Arora diagnose him with a failed vegal nerve, which he opined was the root of the pain. In his records, Dr. Arora addresses the cause of the vegal nerve injury and states that if he had damaged the nerve after the first fundoplication, one would think that he would have had symptoms then. He stated Petitioner did not have pain then, thus; the pain developed after the second fundoplication rather than the first. The Arbitrator notes an opinion from a physician at Mayo Clinic typically bears significant weight. If the treatment up to the time of Dr. Soper's treatment and thereafter was opined to be reasonable and related to the work injury by both Dr. Soper and the IME physician, then it stands to reason that the vegal nerve injury found by Dr. Arora, who opined it was likely brought about by the second fundoplication surgery, and all subsequent treatment for same, is also causally related to the work incident.

The Arbitrator notes there were no other medical opinions presented to provide an opinion that ANY of Petitioner's treatment was not causally related to his work incident. As such, the evidence presented demonstrates the current condition of ill-being was causally related to his work 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?

Given the injury arose out of and in the course of employment and was causally related, the medical services rendered to petitioner after the incident and up to the time of hearing were reasonable and necessary to treat his condition.

Petitioner's treatment consisted of returning to Dr. Dillon, whom after not appreciating the cause of the pain, referred him to Northwestern, where he saw Dr. Hirano, Dr. Soper. After a variety of tests, it was determined that he did have a new hiatal hernia and surgery was needed. Dr. Soper's opinion within the records indicates the treatment performed by him was reasonable and necessary. After Petitioner had continued complaints of pain after his redo fundoplication, more tests were ordered and Petitioner was referred to Dr. Naggpal, a pain specialist and Dr. Doerfler, a dietician, both of whom treated him for his ongoing condition. After the cause of his continued pain could not be determined, Dr. Soper referred him to Mayo Clinic, the best of the best – to determine the cause of his pain.

While at Mayo Clinic, Petitioner was diagnosed with some serous conditions including dumping syndrome, dyspepsia, and a vegal nerve injury, which Dr. Arora opined was likely brought about after the second fundoplication surgery. Dr. Arora opined that Petitioner's vegal nerve was non- functioning and thus, he would require prolonged therapy for this functional disorder that may include medications, neuromodulation therapy, as well as cognitive behavior therapy. He noted he felt this condition would go on for several years. (PX 14). In the immediate future, he recommended a pain management program that would require Petitioner to stay at Mayo Clinic for roughly three to four weeks, which Petitioner testified he scheduled for September 6, 2016.

The records indicate only a small portion of Petitioner's medical treatment was paid for by Respondent. Respondent's Exhibit #5 sets forth the only bills it has paid in this matter, which relates to Northwestern bills for dates of service for May 28, 2013, June 7, 2013, June 24, 2013 and July 2, 2013, as well as one date of service for Good Samaritan Hospital on February 1, 2013. No other treatment has been paid for by Respondent.

Based upon the testimony, the Arbitrator finds the medical services that were provided to Petitioner were reasonable and necessary and that Respondent has not paid all appropriate charges for all reasonable and necessary medical services to date. Respondent shall pay reasonable and necessary medical services per the fee schedule as delineated in Petitioner's Exhibits 1 through 16 within the confines of Sections 8(a) and 8.2 of the Act. Respondent shall further pay for the rehabilitation program recommended by Dr. Arora at Mayo Clinic within the confines of Section 8(a), 8.2 of the Act and the fee schedule, as the treatment was reasonable prescribed to treat the medical condition related to the injury herein.

K. Is Petitioner entitled to any prospective medical care?

The Arbitrator notes that each doctor in this case, Dr. Soper, Dr. Arora and Dr. Mosier have opined that Petitioner will need continued medical treatment. No doctor has found Petitioner to be at maximum medical improvement.

Dr. Arora from Mayo Clinic has most notably opined that Petitioner's vegal nerve was non-functioning and thus, he would require prolonged therapy for this functional disorder that may include medications, neuromodulation therapy, as well as cognitive behavior therapy (counseling). He noted he felt this condition would go on for several years. (PX 14). In the immediate future, he recommended a pain

management program that would require Petitioner to stay at Mayo Clinic for roughly three to four weeks, which Petitioner testified he scheduled for September 6, 2016.

Based upon same, the Arbitrator finds Petitioner is entitled to prospective medical care, including the proposed pain management program at Mayo Clinic.

M. Should penalties or fees be imposed upon Respondent.

The Arbitrator notes there was no denial made on this case until June 10, 2015 when a letter was sent to Petitioner on that day. This was nearly two years after his accident. At no time prior to that date was there a reasonable basis to deny Petitioner's claim. In fact, the IME that Respondent had conducted by Dr. Mosier found there was "likely some relation here to the current condition being related to overdoing it with heavy lifting in the relatively recent postoperative period following the first surgery...and there was an acute change with the lifting that caused acute substernal chest pain, with radiation to the back." He also noted the second operative report "would suggest that there might have been some pulling or tearing of the wrap that was the cause for this". At the time of his report, he opined that the medical care rendered had been reasonable and necessary, that petitioner had not met MMI, and that the treatment plan was reasonable. (RX 7).

The carrier had no reasonable basis to deny Petitioner's claim given the opinions of its own IME physician. The only basis possible for the defense of this case and the imposition of penalties would be on the basis of notice of accident. However, at no time up until the time of hearing did Respondent ever argue it had no notice of Petitioner's accident. Certainly, Respondent can assert different defenses at hearing. However, what is instructive in this case, is that Respondent actually set forth a reason for its denial in its letter of June 10, 2015, which makes no mention of a denial on the basis of notice or accident. Rather, the letter says that "ongoing medical treatment has been determined to be unrelated to the work injury". This would imply Respondent was not disputing whether there was a work injury, nor was notice ever mentioned. The tenor of the denial letter was specifically based upon what purports to be a causation defense. Yet, a cuasation defense was contrary to their own IME physician's opinion, which was rendered a year prior to the denial letter.

Respondent's assertion of lack of notice of an accident at work at the time of hearing was a last-minute defense based soley on what it perceived was an inaccurate date of accident filed by Petitioner. It is clear that the defense that was intended to be asserted at trial was merely that Petitioner did not sustain an injury on January 26, 2013 as was originally listed on Petitioner's Application. This was the only defense the employer could make – an attempt to catch Petitioner on a technicality by arguing that there was no injury on January 26, 2013 because there could not have been an accident on that day because that was a weekend when Petitioner was not even working. Their posture and tenor as viewed in letters up to the point of trial never once mentioned accident or notice as a defense, which all the more demonstrates their notice of the accident and certainly shows the vexation to which this Respondent went in denying benefits to Petitioner.

The evidence demonstrates only some medical bills were paid for treatment at Northwestern for dates of service May 28, 2013, June 7, 2013, June 24, 2013 and July 2, 2013, as well as one date of service for Good Samaritan Hospital on February 1, 2013. Essentially, no payment of medical has been made after July 2, 2013 to the time of hearing. This would amount to 1,078 days of non-payment of medical benefits up to the hearing date of June 16, 2016.

The Arbitrator therefore finds Petitioner is entitled to penalties and fees under Sections 19(l) in the amount of $10,000.00, the maximum award, as this would amount to less than the total of $30.00 per day from July 2, 2013 through June 16, 2016 (which would amount to $32,340.00).

The Arbitrator finds Petitioner is entitled to penalties and fees under Section 19(k), which amount to 50% of the amount payable at the time of the award, in this case 50% of the amounts owed and due for outstanding medical charges within Petitioner's Exhibits 1 through 16.

The Arbitrator finds Petitioner is entitled to penalties and fees under Section 16 that amount to attorney's fees for 20% of the amount awarded for past outstanding medical bills owed within Petitioner's Exhibits 1 through 16, pursuant to the fee schedule.

O. Is Petitioner entitled to mileage reimbursement to/from Mayo Clinic?

Based upon the finding that the injury to Petitioner arose out of and during the course of employment and the finding that Petitioner's medical treatment was reasonable and necessary, the Arbitrator also finds Petitioner is entitled to mileage to/from his appointment with Mayo Clinic from his home in Franklin Park. Travel expenses to cover the cost of transportation to and from treatment can be awarded under the same standard of reasonableness and necessity as medical expenses. General Tire & Rubber Co. v. Industrial Comm'n, *221 Ill. App. 3d 641, 651, 582 N.E.2d 744, 164 Ill. Dec. 181 (1991)*. In that case, The Commission found that it was reasonably necessary for the petitioner to travel to and from his doctor's office in Evansville, Indiana and to/from the Wood River Hospital in Wood River, Illinois, both of which were about 90 to 100 miles each from Petitioner's home. As such, it included $ 1,588 in the petitioner's medical expenses award for travel.

Similarly, in a recent case - Cont'l Tire N. Am., Inc. v. Ill. Workers' Comp. Comm'n *(Simpson), 2011 Ill. App. Unpub. LEXIS 2839* – the court awarded travel expenses for travel Petitioner incurred from his home in Jefferson County, Illinois to his treatment with his doctor in St. Louis, Missouri. The Court found the surgery performed by the doctor in St. Louis was medically necessary but unavailable in the local area.

In the present case, Petitioner was first sought treatment at Northwestern Hospital in Chicago, IL. The Arbitrator notes Northwestern Hospital is a premier Hospital in the area. It was only after a second redo fundoplication surgery and a barrage of post-surgical tests performed by Dr. Soper and Dr. Hirano that he was referred to Mayo Clinic for further consultation. The fact that he was referred to Mayo Clinic by Dr. Soper demonstrates the need for a physician of more expertise in the field as Mayo Clinic is recognized as an innovative leading medical institute. The medical treatment performed by Dr. Arora was different than that performed by Dr. Soper in that the testing performed was unique, including the sham feed test, which ultimately lead to the diagnosis of his vegal nerve . The treatment was reasonable and needed to cure his condition. It was based upon a referral from his treating specialist in the Chicago area, and thus the need for it was reasonable and necessary. Like the court in General Tire and - Cont'l Tire N. Am., Inc, the inference can be made that there was no other doctor in the Chicago area that could offer the same services to Petitioner as Mayo Clinic. If a leading institution in Chicago could not provide reasonable treatment and referred him out, then likely no other doctor in the Chicago area could. As such, the need to travel for treatment at Mayo Clinic was reasonable and necessary.

Petitioner testified the route from his home to Mayo Clinic was approximately 340 miles each way. Petitioner testified he followed the rout listed on Mapquest.com, which was entered into evidence as Exhibit #7. Per Mapquest, the route was 337.1 miles each way.

The Arbitrator notes that per the Illinois Workers Compensation Commission's website, the current State of Illinois mileage rate is $.54 per mile. Per his testimony and via medical records, Petitioner travelled to Mayo on 11 occasions up to the time of hearing, as follows: 7/9/15, 7/20/15, 7/28/15, 8/24/15, 9/10/15, 12/3/15, 2/3/16, 3/15/16, 4/18/16, 5/19/16, and 5/25/16. For these 11 visits at the aforementioned rate, Petitioner would be due a total of $364.07 round-trip for each visit (337.1 x .54 x 2) or a total of $4,004.77 for the 11 visits. Given Petitioner is making a claim for prospective medical, he would continue to be entitled to travel reimbursement in the amount of $364.07 each time he is required to travel to Mayo Clinic for treatment in the future.

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

Jerome Weatherspoon,
Petitioner,

vs. NO: 12 WC 18432

18IWCC0348

State of Illinois
Department of Corrections-Stateville,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, and the nature and extent of the injury, and being advised of the facts and law, modifies the Decision of the Arbitrator as noted 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 laid out in the Arbitrator's Decision, which is incorporated herein. The Commission affirms the Arbitrator's determination as to occurrence of the accident, the causal connection between the original accident and the injuries sustained, as well as liability for medical treatment and the duration of temporary total disability benefits.

With regards to the assessment of the nature and extent of the injury, the Commission does arrive at somewhat different conclusions than did the Arbitrator. The Arbitrator properly reviewed the five factors enumerated in Section 8.1b in arriving at his conclusions that the claimant had established disability to the extent of 55% and 60% of his left and right legs. However, the Commission weighs the evidence somewhat differently than did the Arbitrator.

18IWCC0348

The Arbitrator noted AMA ratings by Dr. Coe of 37% impairment to the right knee and 25% to the left knee, and gave greater weight to this factor. The Arbitrator also gave significant weight to the claimant's employment as a correctional officer. The Commission does not disturb these findings. However, the Arbitrator gave greater weight to the petitioner's age (54 at the time of injury and soon-to-be-59 at the time of hearing) without discussing how the claimant's age would impact the extent of the disability. More significantly, the Arbitrator noted some significance to the claimant's description of persistent limitation on walking, standing, stair climbing, and capacity for rapid response to emergency situations. The Arbitrator opined that this could affect the claimant's future earning capacity and awarded some significance to that finding. However, in this regard the Commission awards greater weight to the fact that the employer had promoted the claimant to sergeant, which would presumably carry a pay increase, and that the claimant had no formal work restrictions, which suggest that any limitation on the claimant's future earnings would be negligible.

In light of the totality of the evidence and the Section 8.1 factors, the Commission finds that permanent partial disability would be more appropriately assessed at 45% loss to each leg, and modifies the Arbitrator's award accordingly. All other findings are affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $685.80 per week for a period of 173.5 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent loss of use of 45% of Petitioner's left leg and the permanent loss of use of 45% of Petitioner's right leg.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JUN 4 – 2018

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-05/23/18
jdl/ac
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEATHERSPOON, JEROME
Employee/Petitioner

Case# **12WC018432**

ST OF IL DOC STATEVILLE
Employer/Respondent

18IWCC0348

On 11/14/2016, 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 0.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0924 BLOCK KLUKAS & MANZELLA PC
MICHAEL D BLOCK
19 W JEFFERSON ST
JOLIET, IL 60432

5875 ASSISTANT ATTORNEY GENERAL
STEPHANIE KEVIL
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CHICAGO, IL 60601

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

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

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

NOV 14 2016

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

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

JEROME WEATHERSPOON
Employee/Petitioner

v.

STATE OF IL DOC STATEVILLE
Employer/Respondent

Case # **13** WC **18432**

Consolidated cases: _____

18IWCC0348

An *Application for Adjustment 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 Faliconi**, Arbitrator of the Commission, in the city of **NEW LENOX,IL**, on **October 6, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **04/17/2012**, 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 **$59,436.00**; the average weekly wage was **$1,143.00**.
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 not*** paid all appropriate charges for all reasonable and necessary medical services.
Respondent shall be given a credit of **$47,899.29** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$47,899.29 for TTD in full to 7/31/2014 per stipulation.**

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services of $316,489.07 , pursuant to the medical fee schedule ($549,599.02 less $233,109.95 paid) as provided in Sections 8(a) and 8.2 of the Act.
Respondent shall be given a credit of $79,344.61 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.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$762.00**/week for 69 6/7 weeks, commencing 04/18/2012 through **08/31/2014 (intermittent per Arb. Ex. 1)**, as provided in Section 8(b) of the Act. Respondent to receive credit of **$47,899.29** for TTD paid hereunder.

Permanent Partial Disability: Schedule injury (For injuries before 9/1/11)

Respondent shall pay Petitioner permanent partial disability benefits of **$685.80**/week for 247.25 weeks, because the injuries sustained caused the 55% loss of the left leg, and 60% loss 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.

Robert E Dalton — Signature of Arbitrator

October 23,2016 — Date

NOV 14 2016

BEFORE THE WORKERS' COMPENSATION COMMISSION

JEROME WEATHERSPOON Petitioner	)	
vs.	)	No.: 12 WC 18432
STATE OF IL DOC STATEVILLE, Respondent.	)	18IWCC0348

RIDER TO ARBITRATOR'S DECISION

IN SUPPORT of the Arbitrator's Decision regarding "C" (Accident Arising out of and in the course of the Employment), the Arbitrator makes the following findings and conclusions:

Petitioner testified that on the date of accident alleged herein, he was a 54 year old 14 year correctional officer for Respondent. Both he and the witness, Correctional Officer Antoinette Florence, had duties that night in Bravo Fell House. Officer Florence was working overtime from the 3:00 p.m. to 11:00 p.m. shift, and Petitioner was working the 11:00 p.m. to 7:00 a.m. shift. Their duties were to make rounds every half hour in the cell house. At 11:30 p.m. and 3:30 a.m. they would do a count, but twice an hour they would be up and down the stairs and walking along the galleries to make sure there were no unusual events and to respond to situations.

Petitioner was at the time of the accident 6 feet, 265 lbs., with a 12 inch foot and size 12 shoe size. He had thick shoulders and bones, having both boxed and played tackle football in the army, where he served six years. With respect to the left knee, which was the one injured in the accident in question, he had a history of arthroscopic surgeries in 1998 and 2009. With respect to the right knee, for which an overcompensation claim is made, he had a history of a prior total knee replacement surgery and then a knee replacement revision surgery in 2009. The left knee surgery and right knee revision were within a couple of months of each other in February and April 2009. He last saw the orthopedist in August 2009, having not seen an orthopedist since then to the time of this accident. A copy of the records of Crystal Lake Orthopedics, where those surgeries were done, (Pet's. Ex. 33) were admitted but only

contained the operative reports. Petitioner had been taking Celebrex sporadically since his 2009 surgeries, originally because of the right knee replacements. Both he and Officer Florence confirmed that he had no limp before the accident and had no problems performing full duties. He had always been fit, having boxed light-heavy weight in the army and testified that he kept himself in a physically fit state

Petitioner began working for the Department of Corrections at Stateville in 1998. Witness Florence began working at Stateville in 1997 and met Petitioner when he began working at Stateville. Witness Florence has a previous workers' compensation claim after alleging that she fell down slick stairs. Witness Florence and Petitioner worked in the same unit at some points during their career, but in April 2012 Petitioner and Witness Florence were not working in the same unit regularly and did not see each other regularly.

On April 17, 2012, Witness Florence was working overtime and happened to be scheduled to work in the same unit as Petitioner. On that night, Petitioner and Witness Florence were working in the Bravo Unit of Stateville Correctional Facility. At approximately 11:30 p.m., they began an inmate count. During an inmate count, each officer would go to each floor of the unit to pass by each cell and visually count each inmate. Bravo unit has five floors named galleries. In this case, the Galleries were named 2, 4, 6, 8, and 10. Gallery 2 was the ground floor, the same floor as the Sergeant's office. To conduct the inmate count on April 17, 2012, Petitioner and Witness Florence ascended four sets of stairs to Gallery 10 and worked their way toward the bottom, Gallery 2. Petitioner testified that he was also asking inmates about the library.

Witness Florence testified that she was walking in front of Petitioner, but that she could hear him behind her. Petitioner testified that he generally liked to be within three of four cells of the other officer doing the count, but that sometimes he would get ahead of him. Petitioner also mentioned that he did not mark down his count until he was on the stairs for each unit because he liked to keep an eye on the prisoners, mentioning another officer who had been stabbed by an inmate through a cell door when he had allegedly been inattentive to his surroundings.

Witness Florence testified that she completed her count and walked down the stairs from Gallery 4 to Gallery 2, then walked into the Sergeant's office to turn in her count sheet. She testified that she could hear Petitioner behind her and that it took her approximately 20 seconds to cross from the bottom of the stairs to the door of the Sergeant's office.

Both Witness Florence and Petitioner described the stairs that they descended that night, as metal grates with grooves in them that are worn down. There are no backs to the steps of the stairs. Witness Florence testified that about 90%the stairs between Gallery 2 and Gallery 4, that both she and Petitioner descended that night, were wet with condensation from the showers which were located nearby. Witness Florence did not specifically remember the stairs being wet on that particular night, but Petitioner did testify that there was condensation present on the stairs.

Petitioner stated that as he was walking down the stairs, he was marking off the boxes on his count sheet and was looking down at the sheet. As he was walking down the stairs, his right leg slipped forward and his left leg got caught in between one of the

stairs; then he jerked forward and landed on his face. He screamed for the other officers to come help him.

Witness Florence also notes in her report that the incident occurred on the Stairway located in front of the Sergeant's office. (Rx 6). Witness Florence did not hear or see Petitioner fall, but she did hear him scream. Petitioner described, in detail, that the particular set of stairs that both he and Witness Florence used to descend from Gallery 4 to Gallery 2 were not visible through the window of the Sergeant's office unless one were looking out one of the corners of the window at an odd angle. Petitioner stated that he was very familiar with the layout of Unit Bravo and that all of the Units in Stateville are set up the same way. Petitioner was clear: he knew that none of the other officers could see him at the time he was walking down the stairs from Gallery 2 or Gallery 4.

Witness Florence did not notice anything was wrong until she heard a scream, about 10 seconds after she had reached the Sergeant's office. She moved out of the Sergeant's office after another officer, Officer Hightower, and found Petitioner lying face down on the sixth step of the staircase coming down from Gallery 4 to Gallery 2. His left leg was caught in between the stairs.

Witness Florence testified that she and Officer Hightower helped Petitioner up. Witness Florence remembers Petitioner being taken from the unit in a wheelchair and her report states that Petitioner was taken from the unit immediately. Petitioner disputes this, claiming that he finished his count on Gallery 2 because he was a little embarrassed about the fall and was trying to look tough. However, when was assigned

to go up to a tower, he decided that he needed to go home because of the pain. Before he went home, though he completed some forms.

On his incident report, dated April 18, 2012, Petitioner stated that after the accident, upon walking around, he determined that the pain in his left knee was increasing and he informed Sergeant Watkins that he needed "to follow through officially on this work injury." (Px 10). On the Workers' Compensation Employee's Notice of Injury form, which he completed at 1:00 a.m. on April 18, 2012, Petitioner noted that the injury occurred at approximately 11:55 p.m. on April 17, 2012. Petitioner also testified that he completed this form prior to leaving Stateville on April 18, 2012. On this form, Petitioner described his injury as "Acute Left Knee Sprain" and "Chronic Left Knee Arthritis." Petitioner also stated that he had previously filed claims for injuries, but did not recall the dates of those injuries.

Petitioner testified that he was eventually wheeled out of Stateville in a wheelchair during the early morning hours of April 18, 2012. He stated that he drove himself home, climbed 13 stairs, took a bath and tried to sleep. Petitioner testified that the pain in his knee was so bad that he eventually went to the emergency room at Provena Saint Joseph Medical Center. The emergency room records reflect that Petitioner arrived at 12:04 p.m. complaining of left leg pain in the hip, ankle, and knee. (Px 1, p. 5).

Witness Florence testified that after Petitioner returned to work on April 24, 2012, she noticed that he had a limp and that she and others offered to do work for Petitioner, such as climb stairs after that date. However, Witness Florence also testified that she

has rarely worked with Petitioner since the accident and that they are not assigned to the same Unit.

Petitioner had two left knee arthroscopies prior to the incident on April 17, 2012; one in 1998 and one in 2009. The 2009 operative report states that Petitioner had extensive arthritis in his left knee with grade II and grade III chondromalacia. (Px 33).

Eight days prior to his fall at work, Petitioner visited his primary care physician, Dr. Ragona, for an unrelated matter that also caused him to be off work and complained of left hamstring and left knee pain. (Rx 3, p. 49). He stated that he had been taking Celebrex sporadically for his left knee pain. *Id.* Petitioner testified that this Celebrex was originally for his right knee, which had already had two total replacement surgeries, but he began taking it for his left knee when he had left knee pain. Dr. Ragona ordered an X-ray of the left knee which showed "Mild arthritic changes involving medial compartment with small spur formation seen off the medial femoral condyle and medial tibial plateau region. Moderate arthritic change is also seen involving the lateral compartment with small spur formation see of the lateral femoral condyle and lateral tibial plateau region. Mild degenerative changes is [sic] seen involving the femoral patellar joint." (Rx 4, p. 222).

At trial, Petitioner claimed that he was only having hamstring pain on April 9, 2012; however, Dr. Ragona's notes clearly focus on the left knee and not a hamstring problem. Dr. Ragona specifically wrote "Pain in L Knee", noted that a scope had been done in 2009 (referring to Petitioner's 2009 left knee arthroscopy), noted that Petitioner

had been taking Celebrex for left knee pain (not hamstring pain) and ordered an X-ray of the left knee.

Petitioner also had an X-ray taken of his left knee on April 18, 2012 when he went to the emergency room. (Rx 4, p. 217). The emergency room physician noted arthritic changes and small suprapatellar joint effusion, and diagnosed Petitioner with acute left knee sprain, chronic arthritis left knee, acute sprains in the left hip and ankle. (Rx 4, p. 218-19). Petitioner was given a knee brace, taken off work for three days and then ordered to do 10 days of desk work before returning to full duty work. (Rx 4, p. 218).

Petitioner visited Dr. Ragona again on April 23, 2012 following-up on his left knee pain and his April 17, 2012 injury. (Rx 3, p. 48). Dr. Ragona noted that Petitioner had a prior history of degenerative joint disease and stated that the X-ray was negative, except for degenerative joint disease. (Rx 3, p. 48). Dr. Ragona returned Petitioner to work full duty on April 24, 2012. (Rx 3, p. 48). Petitioner had an MRI on May 1, 2012. (Rx 4, p. 195-196). The MRI found extensive meniscal changes. (Rx 4, p. 195-196; Rx 2).

Petitioner then visited Dr. Domb and Dr. LaReau of Hinsdale Orthopedics, complaining of left knee pain. (Px 3, p. 8-13). Both doctors approved him to work full duty. Id. (Rx 2.) A left total knee replacement was recommended due to the severity of Petitioner's degenerative joint disease. (Px 3, p. 8-13). On June 8, 2012, Petitioner presented to Hinsdale Orthopedics requesting a cortisone shot in his left knee. (Px 3, p. 15). Dr. Malinowska, who performed the cortisone injection explained that Petitioner would need to wait at least three months after this injection before proceeding with any

knee replacement surgery. *Id.* Petitioner worked full duty until October 10, 2012 and had a left knee arthroplasty on October 12, 2012 performed by Dr. LaReau. (Px 4A).

Following his first total knee replacement surgery, Petitioner was placed in an in-patient rehabilitation center and then followed a course of physical therapy. He returned to work on April 1, 2013. During Petitioner's recovery from that surgery, he continued to complain of pain and was eventually referred to Dr. Alden for a second opinion. On October 28, 2013, Dr. Alden performed a revision of the left total knee replacement.

Petitioner had a right total knee replacement in 2002 and a revision of that replacement in 2009. Petitioner claimed that he started to experience right knee symptoms before the revision of his left knee replacement, but he thought it would go away after the second surgery. However, Petitioner also noted that he was experiencing some right knee symptoms before his alleged accident, when he stated that he was taking the Celebrex for right knee pain and left knee pain.

The medical records reflect that Petitioner complained to Dr. Alden about right knee pain in December 2013. (Px 3, p. 112). Dr. Alden evaluated the knee and performed a revision of the right knee arthroplasty on March 10, 2014. (Px 8C). Petitioner followed a course of physical therapy and work conditioning and was released back to work on September 1, 2014. Petitioner has been working at full duty since that time. Petitioner was promoted to sergeant on April 16, 2015.

Wherefore, based on the record as a whole, and noting specifically the unrebutted testimony of the witnesses in this case, supportedin main part by medical records and other documentary evidence as set forth above, the Arbitrator finds that

Petitioner did sustain an accident arising out of and in the course of his employment by respondent on April 17, 2012 as alleged herein.

In Support of the Arbitrator's Decision regarding "F" (Causal Connection) the Arbitrator makes the following findings and conclusions:

The Arbitrator incorporates the findings set forth above in issue (C) herein by reference thereto.

There are two issues on casual connection, the first being whether the accident in question caused or aggravated the lateral meniscus tear and Petitioner's left knee osteoarthritis, and the second being whether overcompensation because of the length of time Petitioner was either off of his left leg or limited with his left leg, aggravated his prior right knee revision requiring a second right knee revision surgery.

The Arbitrator will address issue of the left knee conditions first, as they are proximate to the accident.

At the outset it should be noted that Petitioner served six (6) years in the military, and while there boxed in the light heavy weight category and played tackle football, and testified he had a high pain tolerance. April 1, 2009, Petitioner had an arthroscopy of the left knee which included a partial lateral menisectomy and a chondroplasty (Pet's. Ex. 33, p. 9-11). In that surgery, they debrided unstable cartilage and loose bodies of the lateral meniscus and performed an extensive synovectomy and the recession was smoothed over (Id.). Dr. Jeffrey Coe, an Occupational Medicine Physician testified on behalf of Petitioner (Pet's. Ex. 34), with Petitioner having had surgery in April of 2009, in the absence of any intervening trauma, "three years later there might be some additional breakdown along the edge that was trimmed in the lateral menesictomy but the lateral meniscus should be largely intact, so that he would not have mechanical knee symptoms, as referred to in the records as catching, locking and associated pain (Id. @ 13). Petitioner testified his last visit to Crystal Lake Orthopedics was in August 2009, and the next record relevant to the case is eight (8) days before the incident in question, April 9, 2012, when Petitioner saw his general practitioner, Dr. Brian Ragona of Optima Medical Associates, for a follow up visit for an issue regarding a right jaw abscess (Pet's. Ex. 2A, p. 49). The jaw was his initial complaint, but he also complained of left knee pain, which he testified was intermittent, and hamstring pain

which the record shows was constant. At the visit of April 9, 2012, Dr. Ragona did not increase Petitioner's medication at all, or suggest any increase in dosage of the anti-inflammatory medication he was taking on occasion. Dr. Ragona also ordered an X-ray, which performed the same day at Provena St. Joseph Medical Center, where the attending radiologist found mild to moderate arthritic changes, and no acute boney pathology, as of eight (8) days before the accident in question (Pet's. Ex. 1A, p. 1). He also told his doctor about the right knee replacement times two (2), so this appears that this is more of a history than a presenting complaint. The patient also noted that he had been taking Celebrex for left knee pain, which he testified he would do once or twice a week after a particularly hard day at work, as his job involved extensive walking and stair climbing. The record also shows a third issue of his unrelated Statin dosage. Dr. Ragona's next note was following the accident and emergency room visit, when he appeared April 23, 2012, with a history: "patient was walking down metal stairs at work – they were slippery. . . " Dr. Ragona, who was the only MD familiar with Petitioner's knee immediately before and after the accident, diagnosed possible "internal disruption of left knee," and ordered an MRI.

The MRI was performed May 1, 2012 at Presence St. Joseph Hospital (Pet's. Ex. 1A, p. 32), which showed both (1) extensive complex tearing and (2) degeneration of the lateral meniscus (Id. @ 32).

Dr. Chris Alden, a lower extremity joint reconstruction specialist (Pet's. Ex. 11, Dep. Ex. 10-A) testified by deposition. He opined that the complex tear found on the MRI was acute and caused by the injury he sustained (Id. @ 9). He said it would be very unlikely that Petitioner could function full duties as an officer at Stateville because he would have a lot of pain and wouldn't be able to be very mobile with that significant a tear and degeneration (Id @ 9). Throughout the course of both testimony and the medical records, the doctor noted that Petitioner has always been one to attempt to return to work at the earliest. His goal at the RIC consult was to return to full duties at the earliest. But, as it relates to the significance of the tear he sustained, the records clearly show catching and locking afterwards which did not exist 8 days beforehand. Notwithstanding, Petitioner testified that Dr. Ragona had suggested a sitting job, but he asked to return to full duties, and he performed it, although moving with a limp, much

slower, and with his co-workers having to give him assistance, as testified to by Officer Florence.

When Dr. Alden was asked just about the arthritis in the knee, he testified that people could have that kind of X-ray and have full function and minimal or no problems with just that, also noting that they see people with mild arthritis that do have pain (Id @ 10-11). Dr. Alden also noted that the original records of Hinsdale Orthopedics show that Petitioner did have catching and locking and complaints of weakness following the accident, for which he was taking Hydrocodone which he did not require before (Id. @ 11-12). Dr. Alden also confirmed that catching, locking and spasms are the symptoms of a meniscal tear which most likely evidence that they were a result of the accident (Id. @ 12-13).

Dr. Alden's impressions of Petitioner as a patient at first he was very likable, seemed straightforward and honest and didn't get a sense of malingering. Dr. Alden did not believe there was any exaggeration of his symptoms whatsoever. (Id. @ 13 -14). Dr. Alden also noted that the records reflect the desire to return to work at the earliest time throughout (Id. @ 14).

Dr. Alden also referred to the impression of his colleague, Dr. Domb, who had seen the Petitioner following the accident but earlier on in the course of treatment, on May 29, 2012, that his impression was left knee pain with osteoarthritis changes, but a new injury from a fall which occurred at work a month earlier with catching and locking, for which Dr. Domb provided a hinged knee brace which Petitioner never needed before (Id @ 14 – 15). There was no evidence that Petitioner ever required an orthopedist since 2009 before coming to Hinsdale Orthopedics in 2012 (Id. @ 15).

Dr. Domb also noted, as did Dr. Ragona's eight days before the accident, that he had a previous occasional knee pain, but not to this extent (Id. @ 17). At that visit of May 29, 2012, Dr. Domb scheduled a total knee pending clearance from workers' compensation (Id. @ 17). Petitioner also reported to Dr. Ragona that the doctor at Hinsdale Orthopedics told him he needed a left knee replacement as of May 29, 2012 (Pet's. Ex. 2A, p. 43). Thus six weeks after the accident Petitioner went from not needing an orthopedist to a script for total knee arthroplasty.

Regarding medical causation, Dr. Alden testified that the injury exacerbated an underlying problem with his left knee necessitating the need for a total knee arthroplasty on the left side. Unfortunately, that knee prosthesis did loosen after the original surgery and he required a revision arthroplasty on the left side as well (Id @ 29). Dr. Alden said he believed it was an acceleration of an underlying problem. Arthroscopy would have been of no benefit, and that's why arthroplasty was recommended. Dr. Alden testified that he had no doubts the accident accelerated the need for the left knee surgery (Id. @ 30). As he explained, even with bone on bone, that does not necessarily mean that Petitoner needed a total knee surgery, but may indicate a need in the foreseeable future, as both the pathology and symptomatology must be present (Id. @ 30 – 31).

In addition to Dr. Alden's testimony, the records of his colleagues also opine causal connection from the accident in question. Dr. Domb in the very first visit had the impression that Petitioner had left knee pain with osteoarthritis changes, but from a new injury from a fall which occurred at work a month ago "with catching and locking." (Pet's Exhibit 3, p. 10). Dr. Lareau, who was to perform the surgery originally prescribed May 29, 2012, assessed "left knee significant osteoarthritis, mainly in the lateral compartment exacerbated by a recent work injury." (Id @ 13). As stated earlier, Dr. Ragona, the general practitioner who had seen Petitioner immediately before and after, was under the impression that there was internal derangement. Finally, Dr. Jeffrey Coe, on behalf of Petitioner, reviewed all the records in question, including Respondent's record review, and opined there was causal connection (Pet's. Ex. 34, Dep. Ex. 2, p. 9 – 10). Dr. Coe also explained the mechanism of injury, that when there are unbalanced eccentric movements of the left knee without guarding, it causes breakdown of the soft tissues within the knee including the meniscus and cartilage surfaces of the knee, which can cause pressure and accelerate the progression of osteoarthritis, as once these soft tissues have been injured the pressure relationships within the knee change and there is no longer even distribution of weight within the soft tissue structures, so it doesn't slide or glide and the abnormal movements accelerate the pre-existing changes and make the knee deteriorate much more rapidly (Id. @ 34 - 39). Dr. Coe also noted that a steroid injection was tried in the knee in the interim (Id. @ 31). Dr. Coe also noted that there was 10 years between Petitioner's two previous left knee surgeries, when he

became aware of the 1998 left knee surgery, so that he was ok as of then and was able to get more than 10 years out of the first surgery (Id. @ 97).

The contrary medical evidence is Respondent's Exhibit number 2, a record reviewed performed by a Dr. Andrew Kim of M&M Orthopedics. His credentials are not in evidence, but from the letterhead it appears he performs general orthopedics, sports medicine and adult reconstruction. He opined there is no causal connection between the accident and Petitioner's knee condition, on page 4 of his report, because in Paragraph C he notes that there appears not to be any acute physical findings, yet in Paragraph D claims "the evidence of the effusion resolved by June 5." This is inherently inconsistent, since the effusion is an acute finding, especially with a claim by this doctor that it resolved by June 5th. Dr. Alden testified that most likely the effusion was acute (Pet's. Ex. 11, p. 7) and this would be especially so in light of Dr. Kim's claim that the effusion resolved by June 5th. As to whether the lateral meniscus tear was acute or chronic, Drs. Alden and Coe clearly felt it was acute, especially since prior problems with the lateral meniscus had been debrided and smoothed out just three years earlier. Finally, Dr. Kim's opinion of no causal connection was based on the fact that Dr. Lareau and Dr. Domb allowed Petitioner to return to work when seen early on. In fairness to Dr. Kim, he did not have the testimony of Officer Florence that while Petitioner returned to work, he had a severe limp, moved slowly, and required assistance from his co-workers. He also didn't address, as did Drs. Alden and Dr. Coe, that the catching and locking noted by the Hinsdale Orthopedist were clear meniscus symptoms which Petitioner only had following the accident of April 17th.

Based upon all the medical evidence it is clear to require knee arthroplasty both the pathology and the symptomatology must be severe. As Dr. Alden testified: "If we went out and got an X-Ray of everybody walking around out there we would find people with bone on bone arthritis. That doesn't mean that they require any type of surgery or any intervention for that matter." (Pet's. Ex. 11 @ 31). In Petitioner's case he may or may not have had the pathology, but he clearly did not have the symptomatology before this accident, and clearly did immediately following to the time of surgery, irrespective of his efforts at returning to work, albeit with a limp, and new symptoms of catching,

locking and weakness, all while needing assistance which had not been required before.

Compensation has been awarded where knee arthroplasty has been discussed before, *Clutterbuck v. UPS, 15 I.W.C.C. 0046*, but here there was never any such discussion, and Petitioner was performing full duties involving extensive walking and stair climbing without difficulty. According, the Arbitrator finds the chain of events clear and convincing, and the medical evidence and testimonies of Drs. Alden, Lareau, Domb, Ragona, and Coe, more persuasive than the opinions of Dr. Kim, which are based on a lack of adequate findings when there were at least two such findings, effusion and a torn lateral meniscus. The Arbitrator therefore finds that causal connection exists between the accident as alleged herein and Petitioner's right knee injury as described in the medical records and set forth above.

Regarding the overcompensation claim for the right knee, Dr. Alden testified that a knee revision done in 2009 would be expected to last 10to 15years (Pet's. Ex. 11 pp. 25 – 26). With Petitioner having had a left knee arthroplasty and then a revision surgery, on December 11, 2013, he reported to Dr. Alden: "The patient states that his right knee has become painful over the past several months because of the stress taken out by the right knee due to the multiple surgeries on the left knee. The pain is localized to the medial knee. The quality is described as being sharp. Patient denies night pain or rest pain. Aggravating factors are walking and stair climbing. Associated symptoms include weakness and instability. Symptoms occur during activity . . ." (Pet's. Ex. 3, p. 112). Walking and stair climbing, by the undisputed evidence, is what Petitioner did extensively at work.

Petitioner testified, and it is undisputed, that he had worked April 1, 2013 through October 25, 2013. Thus approximately six weeks after he ceased working, which is less than "several months", Petitioner reported his pain to Dr. Alden. Petitioner testified that his symptoms began while working, but that he thought that once he had his left knee revision surgery, the overcompensation pain would stop and his right knee would simply heal up. The testimony is consistent with the history to Dr. Alden that the symptoms had been present for several months, as several months earlier they would have clearly arisen during the time frame he was working. Dr. Alden testified that Petitioner was

favoring the left knee and that put more stress on the right knee, he already had had a revision there, and he thought it accelerated his need for the revision of his right total knee (Pet's. Ex. 11, p. 26). Dr. Alden actually wrote in the operative report: "The patient had significant difficulty and problems with the left knee and required a revision as well, this originated from a work injury on 4/17/2012. The patient had loosening of the left knee arthroplasty and because of prolonged aberrant weight bearing and inability to bear weight on the left side the patient had increased stress upon the right knee and had loosening which became apparent in the course of serial X-rays." (Pet's. Ex. 3, p. 202). (Pet's. Ex. 11, p. 27). Dr. Alden felt that with Petitioner having had a revision knee already on the right side, with the right knee taking up all the stress for the weight of the body accelerated the loosing and necessitated the knee for a revision of his revision right knee arthroplasty (Pet's. Ex. 11, p. 28). Dr. Alden explained that overcompensation injuries such as Petitoner had in his right knee is something he sees in his practice, as the stress of weight bearing is taken up by the contralateral extremity, and they see quite frequently pain or problems on the other side (Id. @ 31 – 32).

The doctor also noted that whether Petitioner was partial weight bearing or had no weight bearing because of his own compensatory mechanisms on the left knee and multiple surgeries, the pain he had in the preemptive time between the injury and the subsequent revision arthroplasty was relatively extensive. During that period of time all the stress of the body was taken up by the right knee implant which was already a revision, so he believed it accelerated the loosing and the eventual need for revision for the right knee (Id. @ 32). Factually, from April to the end of October, 2013, Petitioner performed his full duties at work as described earlier, involving extensive walking and stair climbing up to the time of his left knee revision, and from then to December 11, 2013 he was off with only partial weight bearing on his left leg, when he complained to Dr. Alden of the right knee. Petitioner and Officer Florence both testified that during this time period Petitioner was limping and favoring his left leg.

Dr. Coe explained that the reason for the right knee surgery was the breakdown of the tibia component of the right knee prosthesis (Pet's. Ex. 34 p. 46), that he worked from April until roughly the end of the October, started therapy in November and then

had complaints in December consistent with a treated left knee that has been painful for quite some time for which Jerome had undergone two knee replacements surgeries on the left, physical therapy and work hardening, and he did ok with regard to the left knee but during this course of recovery from the left knee he started to develop right knee symptoms. "This is a classic presentation of an overstress or overuse of the opposite leg, the uninjured leg." (Id. @ 46 - 47).

Dr. Coe explained that this was a significant period of time where he favored the left side and that does put unusual and asymmetric pressure on the opposite right side, where, unfortunately he had a breakdown in the prosthesis requiring a repeat surgery by Dr. Alden in March of 2014. It has to develop overtime, so this is a loosening and that loosening because of unusual stresses on the knee prosthesis that cause the tail, the root of this prosthesis, a metal piece, to begin to loosen up in the channel of the leg bone, so this is something that develops over a period of time and is known in the medical literature (Id @ 47 – 48).

Dr. Coe noted that other than asymmetric loading there was no other reasonable explanation as to why the tibular component in the knee became loosened (Id @ 49 - 50). Unless there is a fracture, which had not occurred in the present case, the overcompensation loosening is a discomfort that grows increasingly severe over a few months (Id. @ 98). The only contrary opinion is that of Dr. Kim, who reviewed the records only and never saw Petitioner. Actually, his opinion was not that there was no causal connection, but rather that: "while the good right knee will be called upon to do more work during the recovery period from the two major left knee surgeries, I do not believe that the overcompensation was a major contributing factor to the failure of the right total knee replacement." The Arbitrator notes that pursuant to such cases as *Sisbro v. Industrial Commission*, 207 Ill. 2d 193 (2003) the proper issue for legal causal connection is not whether overcompensation is a major contributing factor, but rather whether it is a contributing factor (Id. @ p. 5).

The basis of Dr. Kim's opinion contained two false assumptions. The first, at page 6 of his report, is that during the recovery from his left knee replacement surgeries, his overall demand and activity level during these times would be much lower than it otherwise would have been if he were in his usual healthy state. The assumption

is that he was recovering from two major surgeries and was not working. The evidence is quite to the contrary, that he was in fact working from April 1, 2013 through approximately the end of October, which was approximately six weeks before the symptoms were reported. The second basis of the doctor's opinion, also at page 6, was he felt that the major causes of the failure of the total right knee replacement would include obesity, two previous right total knee replacements and being middle aged. Dr. Alden, who actually saw and treated Petitioner, made it clear that BMI was the most important issue regarding weight, and that according to the studies, it would be a risk factor if it was 35 or above. Further, being middle aged versus being younger is not a risk factor (Pet's. Ex. 11, p. 46). Further, he testified that Petitioner was not obese at the relevant time and looking at the records, his BMI was only 30.2, his weight at that time was 235, and he is a muscular guy who he would not consider to be obese (Id. @ 49). Dr. Kim was likely referring to an earlier record where Petitioner was weighed 260 or more pounds, but he hadn't by Dr. Ragona's records since February 21, 2013, being down to 245 lbs. by July 29, 2013. (Pet. Ex. 2 pp. 20, 28).

The Arbitrator further notes that the the Supreme Court hasfound that if the work injury itself causes a subsequent injury, the chain of causation has not been broken. "Clear illustrations of this claim of causation relationship are cases where a second injury occurs due to treatment for the first . . ." *International Harvester v. Industrial Commission*, 46 Ill. 2d 238 (1970). Accordingly, the Arbitrator finds the testimony of the treating doctor, Dr. Alden and of Dr. Coe much more persuasive than the opinions of Dr. Kim, and finds that Petitioner's right knee revision surgery as alleged herein was due to overuse or overcompensation as testified to by Petitioner, Drs. Alden and Coe, and as noted by Dr. Alden in the actual operative report and is therefore causally connected to the accident as alleged herein.

In Support of the Arbitrator's Decision "K" (Temporary Total Disability), the Arbitrator makes the following findings and conclusions: See Arbitrator's findings as to C and F.

The evidence shows Petitioner was off work from April 18 through April 23, 2012, from October 10, 2012 through March 31, 2013 and October 20, 2013 through August 31, 2014, for a total of 69 4/7th weeks. Petitioner's treatment initially was for his two left

leg surgeries, and then after having the right knee revision he had physical therapy and work conditioning for both knees. He returned to full duties September 1, 2014. It appears that all of the relevant periods he was off under doctor's care and restricted from work and recovering from the medical treatment that has been previously described. He completed physical therapy August 19, 2014, the latter part of which was for both knees, and was released to return to work as of September 1st. Accordingly TTD is awarded for the above dates , with a credit to Respondent for what it paid, and with Respondent to pay the unpaid TTD per for the period August 1, 2014 through August 31, 2014, being 4 3/7 weeks.

In Support of the Arbitrator's Finding as to "J" (Medical Expenses and "N" "Credit" and Hold Harmless), The Arbitrator makes the following findings and conclusions:

All the bills except Exhibits 18, Radiologists of DuPage, and 29, Associated Pathologist of Joliet, were admitted without objection. However, the Arbitrator assumes Respondent intended to have the bills admitted subject to their objection on liability. Regarding Petitioner's Exhibit 18, it is a bill for radiological services from October 12th through October 13, 2012. October 12th was the date Petitioner had his first total knee replacement (Pet's. Ex. 4A), and he was an inpatient at Advocate Good Samaritan Hospital. The bill is only $427.00, and while there are charges for a chest exam and pulmonary ventilation and a scan of the veins in the leg, it appears that the doctors were taking measures to prevent falls and deep vein thrombosis while Petitioner was on significant medication, and doing customary monitoring, and thus these tests were ordered (Pet's Ex. 4, records of Advocate Good Samaritan Hospital (pp. 130-131). It appears in addition to Dr. Lareau, a Dr. Beltran ordered a number of tests to monitor Petitioner's heart, lungs and the like, which are typical when a hospital patient will be bedridden, and is conservative care which the Arbitrator awards (Pet's. Ex. 4 pp. 259 – 267). The tests were part of Petitioner's inpatient hospitalization, and Dr. Coe testified all treatment was reasonable and necessary (Pet's. Ex. 34, p. 53). Accordingly, Petitioner's Exhibit 18 is awarded.

The other bill objected to was Petitioner's Exhibit 29, from Associated Pathologist of Joliet. Workers' compensation paid the bill in part, and an adjustment was made as

to the balance to make the balance to patient zero. The bills are for October 7, 2013 and February 21, 2014, which appear to be for typical lab work preliminary to surgery. Since the bills were paid by Respondent's workers' compensation administrator, who presumably is able to review bills, and since there is a zero balance, the bills are awarded, but noting there is a zero balance so there is nothing to be paid and no sum will be included in the award.

Regarding all the other bills, with their being no objection and Dr. Coe testifying they were reasonable and necessary and with the Arbitrator's findings regarding accident arising out of and causal connection, those bills are awarded in the total sum of $549,599.02, with a credit for workers' compensation payments in the sum of $233,109.95, and a credit for group insurance payments in the sum of $79,344.01 with Respondent to hold Petitioner harmless from any group reimbursement claims pursuant to Section 8 of the Act.

In Support of the Arbitrator's Decision regarding "L" (Nature and Extent of the Injury), the Arbitrator makes the following findings and conclusions:

All findings previously made herein are incorporated herein by reference thereto. Because this accident occurred after September 1, 2011, and because Petitioner has returned to full duties, the nature and extent of the injury is limited to disability of each of his legs, pursuant to Section 8(e) and 8.1 (b). At the outset, the Arbitrator notes throughout the pendency of this claim, Petitioner appeared to be an excellent employee who was always motivated to return to work. In examining the first rehabilitation evaluation following his left total knee replacement at Advocate Good Samaritan Hospital, under number 7 of the rehabilitation issues it note: "The patient wants to go back to his job as soon as possible . . ." (Pet. Ex. 4, p. 129) When he first went to Dr. Ragona the doctor suggested sitting duty but Petitioner advised he wanted to return to attempt full duties, which he did with assistance. After the second knee revision, he was one month ahead of schedule in his rehabilitation. Following the accident in question, which Dr. Coe felt was a major accident (Pet's. Ex. 34, p. 37) Petitioner was left with a total knee replacement on the left, and then a revision total knee replacement on the left which was more complicated and difficult than a primary knee replacement (Pet's. Ex. 11, p. 22). He was also left with a second revision total knee arthroplasty on

the right with Petitioner having had prior to the accident a total knee replacement and revision arthroplasty on the right, the latter of which was in 2009.

Dr. Alden testified every time a revision to a total knee replacement is done "..we do have to remove some bone, so every time we go back to reconstruct things we have to use bigger implants, more metal, and more cement which is why revision knees aren't necessarily as good.." (Pet's. Ex. 11 p. 37). He stated that things which stress the knee, like climbing ladders or altercations, put him at risk (Id. p. 36). Petitioner's co-worker, Officer Florence, who the Arbitrator finds credible, testified Petitioner had a normal gait before, returned to work initially after the accident with a significant limp requiring the assistance of co-workers, and finally returned to work where he had performed his duties, but he would be limping and slower than earlier

Turning to Section 8.1b, the first factor is the reported level of impairment under the AMA Guidelines. The only AMA Impairment rating in evidence is by Dr. Coe, which places the final left knee impairment rating at 25% and the final right knee impairment rating at 37% (Pet's. Ex. 34, Ex. 2, AMA Impairment Rating; and Pet's Ex. 32, 2nd from last page). Dr. Coe gave testimony regarding the AMA Impairment Ratings. The Arbitrator gives greater weight to this factor.

With respect to the second factor, the occupation of the injured employee, Petitioner was a correctional officer at the time of the accident and is currently a correctional sergeant. He testifies he still performs extensive walking, as working the night shift he frequently has to do the work of what five Sergeants would do on the day shift, but he did not testify that he is doing the five galleries as he was required to do as a correction officer. However, it is clear that Petitioner is on his feet most of the working day. The Arbitrator considers Petitioner's employment significant in determining the disability.

With regard to the third factor, age, Petitioner was 54 at the time of the accident and was soon to be age 59 as of the time of the hearing. The Arbitragtor gives greater weight to this factor.

Regarding the next factor, the employee's future earning capacity, Petitioner since his injury has been promoted to sergeant, with presumably some increase in his earnings. Dr. Coe testified that he performs pre-employment physical exams, and had Petitioner gone to him for a general duty job consistent with the understanding of what a correctional officer does, the Petitioner would not really be appropriate for that kind of work based on the examination findings, especially the residual bilateral knee tenderness worse on the right than left and bilateral knee stiffness and difficulty and pain going up and down stairs. So Petitioner would not be a candidate for a job requiring walking, standing, and climbing and descending stairs, responding to emergency or urgent situations, or breaking up altercations. (Pet's. Ex. 34 p.60). the Arbitrator finds that this could affect his future earning capacity. The Arbitrator finds some significance in this factor and the aforesaid findings.

With regard to the 5th Element, evidence of disability corroborated by treating medical records, just as Petitioner's restrictions would cause him difficulty in a pre-employment physical as Dr. Coe testified, which could impair future earnings capacity, likewise, this is strong evidence of medical disability. The medical records overall support that he has a disability as a result of a left total knee replacement and then revision left knee arthroplasty, and a right second revision arthroplasty, third total knee surgery. Petitioner testified that his left knee is still painful, it has locked and buckled but the right knee will buckle more, it does spasm even when off work after walking some. He still has difficulty up and down stairs, with his tri-level house having a total of 13 stairs, and even flat surfaces will irritate, especially at work where the surfaces are not completely flat. He will have stiffness when he wakes up and then the knee will loosen when he walks around. The spasm is on a daily basis for the most part, about four or five times a week. Regarding the right knee there is still pain, and there is still difficulty going up and down stairs, and walking will produce spasm, and it will buckle more than the left side and have swelling. He testified as to activities limited by the surgeries. At the time Petitioner was released to return to work, Dr. Alden noted that he could return to work without restrictions, full weight bearing but he still needed to work on strength and gait and quadriceps exercises. He noted that some swelling of the leg is not unexpected given the number of surgeries, and he should only weight-bear as

tolerated. While no formal restrictions, Petitioner was to let his symptoms guide his activity levels. Also, he would need antibiotics prior to any procedures for infection prophylaxis, which is a lifelong precaution. (Pet's. Ex. 3, p. 200).

Based on the foregoing, the Arbitrator awards a disability to the left leg of 55% and to the right leg of 60% thereof pursuant to Section 8(e) and 8b.1 of the Act.

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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Smith,
Petitioner,

vs. NO: 14 WC 38395

Fram Filtration,
Respondent.

18IWCC0349

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of the nature and extent of the injury and mileage expenses and being advised of the facts and law, modifies the attached Decision of the Arbitrator as noted below but incorporates the Decision for factual background.

Regarding the issue of mileage reimbursement, the Commission notes that such expenses can be awarded under Section 8(a) of the Act pursuant to a reasonableness standard, as discussed at length in *General Tire & Rubber Co. v. Industrial Commission*, 221 Ill.App.3d 641 (1991). There, the Appellate Court held the respondent liable for long distance round trip mileage of approximately 100 miles to and from the petitioner's treating physician. However, mileage reimbursement has repeatedly been noted to apply only to unusual or excessive circumstances, and there must be a showing that there is no reasonable available alternative care closer or local to the claimant. In this case, the only basis for the claim for mileage is that the claimant testified that the insurance adjuster did not want to speak to him directly because he had a lawyer, and the petitioner elected to pursue treatment with a more distant therapy provider rather than have either his attorney or a local facility contact the respondent for specific authorization. There was no direct testimony or evidence that authorization was ever refused, however, suggesting rather that the petitioner failed to pursue available options. There is an absence of credible compelling evidence to support a finding that no comparative care existed more locally. Ultimately, the Commission concludes that the submitted travel was not unique or medically necessary, but rather was a personal choice. Accordingly, the award for mileage is vacated.

18IWCC0349

Regarding the nature and extent of the injury, the Arbitrator considered the five factors enumerated in Section 8.1b of the Act and awarded permanent partial disability as a percentage loss to the hand, despite the original injury and laceration being limited to the index finger. While Respondent urges the Commission to award disability expressed only as a percentage loss to the index finger, the Commission concludes that the Arbitrator was correct in that the disability resulting from the injury does appear to extend to the hand, not just the first finger. Dr. Marburger's records note that the petitioner's hand symptoms began manifesting about 4 weeks after the index finger surgery, then noting the petitioner had, "quite a bit of stiffness in the left middle finger." On 12/3/14, Dr. Marburger noted stiffness in all of Petitioner's fingers and swelling in the hand. And on 1/21/15, Dr. Marburger noted "post-op stiffness of the left hand."

However, the Commission, in its review of the evidence, does view the extent of the disability somewhat differently than did the Arbitrator. The Arbitrator noted as follows with regard to the five factors under Section 8.1b:

(i) Disability impairment rating: no weight (no AMA Impairment Rating was offered);

(ii) Employee's occupation: greater weight, because Petitioner testified he has some difficulties performing his job;

(iii) Employee's age: some weight, because the Arbitrator felt that at Petitioner's age of 54, his disability is more likely to impact his ability to perform his job in the future;

(iv) Future earning capacity: no weight, as no direct evidence of reduced earning capacity was in the record; and

(v) Evidence of disability corroborated by treating records: greater weight, because Dr. Marburger's records indicate a progressive problem with his whole hand and other fingers, not just his index finger.

The Commission concurs that no weight should be assigned to the absent AMA report. However, the Commission is not persuaded that greater weight should have been assigned to the employee's occupation and that no weight should have been given to potential future earning capacity, given that the evidence demonstrated that the petitioner returned to work without restrictions on 12/17/14 and that since that time he has been performing his pre-injury job, with no evidence of any reduction in earnings. The Commission affords these some weight. Further, regarding the evidence of persistent disability, the petitioner reported to Dr. Marburger he was "not bad," when asked how he was doing in March 2015. While those records do corroborate disability extending to the whole hand as opposed to just the index finger, the Commission affords them less import than did the Arbitrator. In light of all the evidence adduced, the Commission concludes that an award of 17.5% loss to the left hand is more in line with the extent of the disability demonstrated, and modifies the award accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $600.15 per week for a period of 35.875 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent loss of use of 17.5% of Petitioner's left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of mileage as set out in the Arbitrator's decision is vacated. All other findings of the Arbitrator are affirmed.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,600.00. 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 4 – 2018

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-04/10/18
jdl/mcp
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SMITH, THOMAS
Employee/Petitioner

Case# **14WC038395**

FRAM FILTRATION
Employer/Respondent

18IWCC0349

On 9/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0246 HANAGAN & McGOVERN PC
STEVEN F HANAGAN
123 S 10TH ST SUITE 601
MT VERNON, IL 62864

0180 EVANS & DIXON LLC
DAVID J REYNOLDS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102-2727

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

Thomas Smith
Employee/Petitioner

v.

Fram Filtration
Employer/Respondent

Case # 14 WC 38395

Consolidated cases: N/A

18IWCC0349

An *Application for Adjustment 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, Illinois**, on **September 4, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0349

FINDINGS

On **September 3, 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 **$52,013.00**; the average weekly wage was **$1,000.25**.

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

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

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

Respondent shall be given a credit of **$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

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 **$600.15**/week for **61.5** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **30% loss of the left hand.**

Respondent shall pay Petitioner $1,597.12, for 2,852 miles traveled for medical treatment at 56 cents per mile pursuant to CMS Travel Guide 14-03.

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

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

Michael K. Nowak, Arbitrator

8/24/16
Date

ICArbDec p. 2

SEP – 6 2016

FINDINGS OF FACT:

Petitioner testified that he was employed by the Respondent on September 3, 2014. His duties at that time required him to run a high-speed shell machine, which makes the outside of the casings for oil filters. He also has to maintain three presses, handle scrap material, and fixed about anything that breaks in his job. Petitioner testified that he worked with a metal shredder which would shred scrap steel. On the above date he was reaching in a bin to grab a piece of shredded metal when another piece came out of the shredder at a pretty good speed and struck and injured his left index finger. Petitioner testified that he was struck on the side of the left index finger and it penetrated into his hand. He did not know how deep it went, but noted it wasn't a very big cut.

Medical records from the Wabash General Hospital indicate that Petitioner was seen on September 4, 2014. He presented with a history of having injured his left index finger the day before. The records noted a laceration of the finger and that Petitioner was having numbness, swelling, tingling, and weakness. There was a .5 cm laceration to the radial aspect of the proximal phalanx of Petitioner's left index finger, along with limited movement and diminished flexion secondary to pain and weakness. The records noted diminished sensation over the left index finger consistent with digital nerve injury, and a deficit to the flexor tendon of the left index finger. Petitioner was referred to Dr. Justin Miller at that time.

Medical records from Dr. Miller indicate that he too saw Petitioner on September 4, 2014 as well. Dr. Miller noted a 1 cm laceration on the radial aspect of the finger and a pinpoint laceration on the ulnar aspect of the finger. Petitioner was unable to flex the distal interphalangeal joint. Dr. Miller diagnosed a radial digital nerve laceration, tendon laceration, and referred the Petitioner to Dr. Marburger, a hand specialist.

Petitioner was seen by Dr. Ross Marburger at the hand center of Evansville on September 5, 2014. That time Petitioner was complaining of sharp pain in his index finger, with associated numbness and tingling. Dr. Marburger diagnosed a zone II flexor tendon injury with radial digital nerve laceration. He recommended surgery to repair the injury and noted that the risk of surgery included potential damage to adjacent structures with short or long-term function loss.

Petitioner underwent surgery on September 9, 2014. Dr. Marburger's operative report indicates he found a complete laceration of the flexor tendon and a complete laceration through the radial digital neurovascular bundle at the time of surgery.

Through the course of Petitioner's medical care following surgery, Dr. Marburger's records indicate that Petitioner continued to have complaints of numbness and tingling in his index finger and was also experiencing a progressive decrease in range of motion of the other fingers as well as his hand. On October 7, 2014, Dr. Marburger's notes indicated that even the Petitioner's passive range of motion was unacceptable and that Petitioner was having quite a bit of stiffness in his left middle finger. A week later, Dr. Marburger noted Petitioner had stiffness across his entire hand as well as his other fingers. Petitioner did not have full passive range of motion in his ring and middle finger and noted complaints of mild soreness and stiffness of Petitioner's wrist. At that time, Dr. Marburger placed the Petitioner on a Medrol dose pack to try to decrease the inflammation and help with stiffness. Dr. Marburger questioned the possibility of complex regional pain

syndrome, although Petitioner did not present a clear picture for it. Petitioner was advised to continue his hand therapy.

Dr. Marburger's records and therapy notes indicate that the Petitioner had little lasting relief from the medication. The therapist continued to manually stretch all of Petitioner's fingers in order to increase the active and passive range of motion. In late October, 2014 Dr. Marburger and the therapist recommended Petitioner attempt find therapy closer to his home.

By December 3, 2014, Dr. Marburger's records note that Petitioner continued to have mild swelling and had less than full passive flexio of his index finger with no pull-through. All of Petitioner's fingers remained somewhat stiff, more so with his left index finger. Dr. Marburger recommended another Medrol dose pack, and considered additional surgical intervention at that time although he later indicated he was not optimistic surgery would allow the Petitioner to regain any substantial tendon mobility. The doctor also discussed smoking cessation with the Petitioner.

Through January of 2014, Dr. Marburger noted that mild swelling persisted. Petitioner was having stiffness across the board with less than full active composite flexion. Given Petitioner's stiffness, most prominent in the index finger, he determined that Petitioner was not a candidate for repeat tendon surgery and he was not optimistic Petitioner would become a candidate for surgery in the future.

Petitioner was last seen by Dr. Marburger on March 11, 2015. At that time the doctor's records indicate that the measurements did not determine a substantial improvement in Petitioner's range of motion. The Petitioner wanted to discontinue further follow-up and accept his current result. The Doctor recommended Petitioner continue with his aggressive home therapy. He thought Petitioner would continue to show slow improvement for up to 18 months. Petitioner was released at that time.

Petitioner testified that he has not noticed any improvement in the condition of his hand since his release from Dr. Marburger on March 11, 2015. At that time, Dr. Marburger had suggested that he continue with therapy or exercises. He did so, and does them to this day. It is not helping him.

Petitioner testified that he continues to have problems with his hand. He has difficulty opening jars, grabbing a doorknob and things like that. He can't grip with his hand, so he has to hold things against his belly and use his other hand to work with them. He has difficulty holding screws and things like that because he doesn't have much feeling. When performing minor tasks, like opening a "Coke bottle," he can use the little finger side of his hand to open them rather than his index middle and ring finger. He also uses his thumb for some things.

Petitioner demonstrated the range of motion of his left hand to the arbitrator, consistent with Petitioner's exhibits number four and five, photographs which show the Petitioner's inability to make a fist, leaving approximately 2 1/2 inches in distance between his index finger, middle finger, and ring finger and the remainder of his hand. He is unable to place his hand flat on the table, with only the base of his hand and his fingertips making contact demonstrating a lack of extension and an inability to extend any of the digits on his left hand fully. Petitioner also noted having some limitation of his wrist motion. He cannot fully extend or flex his wrist, although can do so better than the flexion and extension of his fingers.

Petitioner testified that his difficulty in gripping does cause some problems with him doing his job. There are many things he can still do, but he has to work around the condition of his hand. As an example, he testified that if he had a broken a conveyor belt at work he needs to use his hand to get underneath the machine but, he can't get his hand all the way up through it. He also noted difficulty holding things such as an Alan wrench or screwdriver because they're so small. He has not missed any work or lost any hours of over time since his return to work.

Petitioner testified that his index finger is not particularly painful, but feels like it has a band wrapped around it constantly squeezing his finger. His knuckles hurt, especially when he needs to use his hand to get up off the ground or something like that. He notes pain when his fingers are pushed laterally to the side and when his knuckle joints at the hand are pushed against a surface. He believes he would still have difficulty getting a glove over his hand because his fingers don't straighten out.

Petitioner testified that he was required to travel for his physical therapy in Evansville, Indiana. He testified he made 23 trips which were 124 miles round-trip. Petitioner testified that when his therapist in Evansville suggested that he try to find therapy closer to home he called the insurance adjuster, but she refused to talk to him about it. He therefore continued to go to Evansville for therapy.

In addition, Petitioner testified that he made four additional trips, which were double trips from his work to the hospital or doctor in Mount Caramel, for a total of 76 miles.

Petitioner testified that he was a smoker and that Dr. Marburger did explain to him that continuing to smoke was not assisting in his recovery. Dr. Marburger also told him he had some arthritis in his hand.

Petitioner testified that in March of 2015 he told the doctor he was accepting the condition of his hand as it was. He did not want additional therapy. Petitioner said he didn't want to have additional therapy because it wasn't helping. Petitioner testified he continues to do his daily exercises. He has had no medical treatment since March of 2015.

Petitioner testified he was released to full duty approximately January 2015 and has been working full duty since then. He has no job restrictions and is able to perform his activities of daily living as well as his job. He no longer plays golf because he cannot grip a golf club. Petitioner testified he has not had any previous injuries to his left hand or index finger.

Petitioner testified that he has no difficulties with his right hand.

Petitioner and Respondent agree that all TTD, TPD, Medical Expenses and any other interim benefits due to the Petitioner have been paid and are not in dispute.

CONCLUSIONS:

Issue L: Nature and Extent of the Injury

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of

§8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes the record reveals that Petitioner was employed as a machine operator for the Respondent. He was able to return to work in this capacity, but testified as to some difficulties performing his job. Petitioner testified that his difficulty in gripping does cause some problems with him doing his job. There many things he can still do, but his injury has some impact on his performance of the duties of his job. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 54 years old at the time of the accident. Because of Petitioner's age, the disability sustained is more likely to have a greater impact on Petitioner's ability to perform his job into the future. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. 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 Petitioner testified he continued doing the exercises recommended by Dr. Marburger on a daily basis since his release and that he has not noticed any improvement in the condition of his hand. While Dr. Marburger did suggest the Petitioner might notice improvement even up to 18 months after his injury, the lack of any improvement in Petitioner condition over the past six months demonstrates otherwise.

Petitioner sustained a flexor tendon injury to his left index finger and a laceration of the radial digital nerve. He underwent surgery to repair the damage. While the Petitioner's injury was predominantly to his left index finger it is apparent that the injury also affected the function of his entire hand. Dr. Marburger's medical records clearly document a progressive problem with the Petitioner's ability to use the other fingers and his hand, as well as his wrist, following the surgery. The records clearly noted that the risks of the surgery performed could cause damage to the adjacent structures in Petitioner's hand. The arbitrator also notes that the Petitioner's complaints of inability to move his fingers and his whole hand are confirmed by the medical records which consistently showed an inability of the doctor and therapist to achieve even passive motion in Petitioner's fingers and hand as a whole.

Petitioner demonstrated a substantial loss of motion of his fingers, hand, and wrist. He had limited extension and flexion of his fingers and hand, all of which permanently diminish the function of his hand, not just his index finger. Because the medical records and evidence taken as a whole corroborate the Petitioner's complaints of pain, weakness and loss of function in her hands, 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 30% loss of use of his left hand pursuant to §8(e) of the Act.

Issue O: Other - Mileage

Petitioner testified that he was required to travel for his physical therapy in Evansville, Indiana. He testified he made 23 trips which were 124 miles round-trip (2,852 miles). In addition, Petitioner testified that he made four additional trips, which were double trips from his work to the hospital or doctor in Mount Carmel, an additional 76 miles, for a total of 2,928 miles travelled. Petitioner testified that he also had tried to obtain therapy closer to home, but that his claims adjuster would not speak to him to provide authorization. As a result, he continued to travel to Evansville for therapy.

This was an uncontested case with respect to Petitioner's medical treatment. Respondent paid for Petitioner's treatment and obviously had access to Petitioner's medical records, including those in late October 2014 in which Dr. Marburger and the therapist suggested the Petitioner attend therapy closer to home. When Petitioner attempted to switch the location of his therapy, the Respondent's insurance adjuster would not discuss it and did not authorize therapy at a facility more near Petitioner's home. It was reasonable and necessary for the Petitioner to continue to attend therapy in Evansville and Petitioner is entitled to compensation for the mileage traveled to do so. However the mileage claimed for the four trips from work to the hospital and doctor in Mount Carmel is local mileage and is therefore denied.

Respondent shall pay to the Petitioner the sum of 56 cents per mile for 2,852 miles for necessary medical travel, a total of $1,597.12, pursuant to CMS Travel Guide #14-03.

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 Fitch,
Petitioner,

vs. NO: 10 WC 03929

18IWCC0350

Zurich North America.
Respondent.

DECISION AND OPINION ON REVIEW

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

The facts of this case were well laid out in the Arbitrator's Decision, and the Decision is attached to this for reference. The Commission further affirms the Arbitrator's findings on the threshold issue of accident and, to the extent delineated in the Arbitrator's decision, the apparent causal relationship between the accident and the right elbow condition of ill-being.

The Commission modifies the Arbitrator's findings regarding the issue of prospective medical care. While further medical treatment may well be recommended and be reasonable, necessary, appropriate and causally related to the original injury, the Arbitrator's award of "any reasonable and necessary subsequent treatment recommended by Dr. Cohen" is, in this context, both overly broad and somewhat speculative. Depending on Dr. Cohen's assessment and diagnosis, he may recommend deferring action, or doing imaging studies, or recommending passive intervention such as bracing, or active intervention such as physical therapy, or invasive

treatment such as injections or surgery, but it puts the cart before the horse to declare them reasonable before a prescription has even occurred. Accordingly, the Commission concurs with the Arbitrator that a follow-up appointment with Dr. Cohen is reasonable and appropriate, and orders the respondent to pay for same within the limits of Sections 8(a) and 8.2 of the Act. Further medical treatment recommendations stemming from that appointment, if such are disputed, would appropriately be the focus of a future 19(b)/8(a) proceeding.

Pursuant to Section 19(b) of the Act, in no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 20, 2017, is hereby modified as stated above and otherwise affirmed and adopted.

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

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

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

The party commencing the 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 4 – 2018

Joshua D. Luskin

Charles J. DeVriendt

Elizabeth Coppoletti

o-04/25/18
jdl-ac
68

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

FITCH, NANCY
Employee/Petitioner

Case# **10WC003929**

ZURICH NORTH AMERICA
Employer/Respondent

18IWCC0350

On 1/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0700 GREGORIO & MARCO
SEAN C STEC
TWO N LASALLE ST SUITE 1650
CHICAGO, IL 60602

0445 RODDY LAW LTD
CHRIS TOMCZYK
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)

NANCY FITCH
Employee/Petitioner

v.

ZURICH NORTH AMERICA
Employer/Respondent

Case # 10 WC 3929

Consolidated cases: _____

18IWCC0350

An *Application for Adjustment 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 **December 14, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0350

FINDINGS

On the date of accident, January 31, 2007, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$73,477.97**; the average weekly wage was **$1,469.56**.

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

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

ORDER

Respondent shall authorize and pay for a follow-up appointment with Dr. Mark S. Cohen, and any reasonable and necessary subsequent treatment recommended by Dr. Cohen, pursuant to Section 8(a) of the Act.

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

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

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

18IWCC0350

FINDINGS OF FACT

Petitioner's testimony

Prior to January 31, 2007, Nancy Fitch (hereinafter "Petitioner"), a 36 year old right-hand dominant claims specialist, had never injured her right elbow. In addition, she had never received medical care of any kind for her right elbow prior to January 31, 2007 and had never missed any time from work due to right elbow problems.

On January 31, 2007, Petitioner was exiting her place of employment for Zurich North America (hereinafter "Respondent") which is located at 1450 American Lane, in Schaumburg, Illinois. Petitioner was carrying a claims portfolio and other paperwork she was taking home for a claims review that would take place the next day.

Petitioner exited the building, walked across a concrete walkway and proceeded down a set of exterior stairs to the level of the parking garage where her car was located. The parking garage where Petitioner parked her car was an employee parking garage that was owned, operated and controlled by Respondent. In addition, while the petitioner testified that the lot is used by clients, workers and visitors, only employees of Respondent parked where she was parked.

As Petitioner descended the first flight of concrete exterior stairs from ground level, she slipped on the metal lip of the stair that was wet and had become slippery from ice and snow. Petitioner's feet slipped out from under her and she landed on her right elbow. Petitioner felt immediate pain in her right elbow following her accident, but decided to go home and see if her symptoms improved. Petitioner testified that since her fall, the respondent has installed new mats and other safety features to the stairs.

Petitioner's treatment

The next day, February 1, 2007, Petitioner's right elbow was still painful and swollen. Because of her continued symptoms, Petitioner reported her work injury to Respondent and decided to obtain medical care. Petitioner was examined by her general practitioner, Dr. T.S. Giese, on February 1, 2007. Dr. Giese took a history from Petitioner that states, "This Pt is here after a fall down the stairs yesterday." Dr. Giese noted that Petitioner complained of right elbow and right shoulder pain and upon examination, noted that Petitioner exhibited a fair amount of swelling at the tip of the elbow. Dr. Giese opined that Petitioner had suffered a small tip fracture on the elbow and referred Petitioner to an orthopedic specialist for application of a cast. PX11, p. 2.

The same day, Petitioner was examined at McHenry County Orthopaedics by Dr. Warren S. Jablonsky. Dr. Jablonsky examined Petitioner and found evidence of a small abrasion on the tip of the olecranon and mild thickening of the olecranon bursa. Dr. Jablonsky also noted that Petitioner had sensitivity to light touch to the right elbow. The doctor diagnosed Petitioner with a right elbow contusion, with olecranon bursitis. Dr. Jablonsky permitted Petitioner to return to work, but directed

her to ice her right elbow, use anti-inflammatories as needed and use padding on her desk at work to protect her elbow. PX12, p. 8.

On February 19, 2007, Petitioner retuned to see Dr. Jablonsky. Petitioner still had pain and sensitivity in her right elbow, but her swelling had reduced. Petitioner specifically remarked to Dr. Jablonsky that she felt a "ridge" in the area of her right olecranon. Once again the doctor diagnosed Petitioner with a right elbow contusion with olecranon bursitis and prescribed an MRI of the right elbow to further investigate the "ridge" Petitioner complained about. In addition, Dr. Jablonsky provided Petitioner with a prescription for physical therapy. PX12, p. 10.

Petitioner testified that she did not attend physical therapy because she was not experiencing any loss of strength or range of motion, just pain and sensitivity in her right elbow. On February 28, 2007, Petitioner completed the MRI of her right elbow at MRI of Arlington Heights. Dr. Brian J. Murphy, a radiologist, reviewed the MRI and found bone edema in the olecranon process. In addition, Dr. Murphy indicated that he would need to rule out an occult fracture of the elbow versus a contusion. PX12, pp. 20-25.

On March 1, 2007, Petitioner returned to see Dr. Jablonsky, who reviewed the MRI of Petitioner's right elbow that was completed on February 28, 2007. Dr. Jablonsky confirmed the findings of Dr. Murphy and recommended that Petitioner proceed with a course of physical therapy. PX12, p. 13.

Petitioner testified that she again, did not pursue the course of physical therapy because she was not experiencing any loss of strength or range of motion, just pain and sensitivity in her right elbow. Petitioner returned to see Dr. Jablonsky on April 16, 2007. At that time, the doctor noted that there was still a small dimple at the olecranon bursa region with continuing evidence of tenderness involving the area of the olecranon bursa. Dr. Jablonsky again recommended that Petitioner proceed with physical therapy. PX12, p. 18.

Because of her continued symptoms, Petitioner sought a second opinion for her right elbow injury. Petitioner returned to Dr. Giese on November 14, 2008. She complained that "...her right elbow just doesn't feel right after her fracture in February." Dr. Giese provided Petitioner with a referral for a second opinion with an orthopedic specialist of her choosing. PX9.

After waiting over a year for her appointment to be authorized by Respondent, Petitioner was examined by Dr. Mark S. Cohen on January 27, 2010. Petitioner complained of sensitivity over the tip of her elbow with any applied pressure and the sensation of something moving over the tip of the elbow joint. Upon examination, Dr. Cohen noted that Petitioner was tender over the olecranon bursa and he noted a slight defect in the bursa, with a small loose body. Dr. Cohen diagnosed Petitioner with chronic olecranon bursitis with thickening of the bursa and a small loose body. The doctor advised Petitioner to use a Neoprene sleeve or an elbow pad when directly applying pressure to the tip

of the elbow, or, alternatively, to proceed with a bursectomy surgery to remove the loose body. PX13, pp. 3-4.
Because Petitioner was wary of making her condition worse with surgery, she elected to wait and see if her right elbow symptoms improved. Because her right elbow symptoms of pain and sensitivity did not improve over time, Petitioner requested from Respondent that she be permitted to be re-examined by Dr. Cohen in 2012. Petitioner has not been provided with the requested authorization to return to see Dr. Cohen and Dr. Cohen's office has advised her that they will not accept Petitioner's group health insurance or direct payment from Petitioner for the evaluation because it is a workers' compensation claim.

As of the date of the hearing, Petitioner still experiences pain and heightened sensitivity in her right elbow. Based on her ongoing symptoms, Petitioner would like to return to be evaluated by Dr. Cohen for consideration of proceeding with the surgery he recommended for her on January 27, 2010. Petitioner has not reinjured her right elbow in any way since January 31, 2007.

CONCLUSIONS OF LAW

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

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 claimant 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.

The Arbitrator finds that Petitioner suffered an accident that arose out of and in the course of her employment by Respondent on January 31, 2007. The Findings of Fact, as stated above, are adopted herein. Petitioner testified that she slipped and fell while exiting the building where she works, while carrying a claims portfolio and other paperwork she was taking home for a claims review that would take place the next day.

Petitioner had walked across a concrete walkway and proceeded down an exterior set of stairs, adjacent to the lot where the employees parked. Petitioner was headed to the level of the parking garage where her car was parked. As Petitioner descended the stairs, she slipped on the metal coping which was wet and slippery with ice and snow; fell backwards, landing on her right elbow. It is

undisputed that the parking garage and stairwell where Petitioner fell was owned, operated and controlled by Respondent.

The Arbitrator notes that a claimant bears the burden of proving that her injury arose out of and in the course of employment. *First Cash Financial Services v. Industrial Commission,* 853 N.E.2d 799, 803, 367 Ill. App. 3d 102, 304 Ill. Dec. 722 (2006). "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. *Illinois Consolidated Telephone Company v. Industrial Commission,* 732 N.E.2d 49, 51, 314 Ill. App. 3d 347, 247 Ill. Dec. 333 (2000). As a general rule, risks that an employee may be exposed to are categorized into three groups: (1) risks distinctly associated with employment, (2) risks personal to the employee, and (3) neutral risks that have no particular employment or personal characteristics. In the context of falls, employment risks include tripping on a defect at an employer's premises or falling on uneven or slippery ground at the work site. *Id. at 53.*

In the instant case, it is undisputed that Petitioner fell on wet and slippery stairs while carrying a folder of work. It is further undisputed that the stairs on which Petitioner fell are located on Respondent's premises. Based on the foregoing, it is clear that the wet metal coping on Respondent's premises was an employment risk. In addition, the stairs were wet from the ice and snow. Accordingly, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence, that her slip and fall "arose out of" her employment with Respondent.

The Arbitrator further notes that the words "in the course of" relate to the time, place and circumstances under which the accident takes place - - an injury occurring within the period of employment, at a place where the employee reasonably may be in the performance of his duties, and while fulfilling those duties or doing something incidental thereto. *Williams v. Country Mutual Insurance Company,* 28 Ill. App. 3d 274, 277, 328 N.E.2d 117 (1975). It has been long recognized that a person is covered by the Act when going to and from work on the employer's premises. *Id. at 277.*

The Arbitrator finds that Petitioner was on Respondent's premises at the time she slipped and fell. Accordingly, the Arbitrator finds that Petitioner proved, by a preponderance of the evidence that her accident was "in the course of" her employment. Based on the forgoing, the Arbitrator finds that Petitioner has proven, by a preponderance of the evidence, that she suffered an accident that arose out of and in the course of her employment by Respondent when she slipped on the wet metal coping on the stairs and landed on her right elbow, on January 31, 2007.

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 Petitioner's current condition of ill-being, as it relates to her right elbow, is causally related to her work accident on January 31, 2007. The Findings of Fact and Conclusions of Law, as stated above, are adopted herein. The petitioner's testimony, that she had never injured her right elbow, never received medical care of any kind for her right elbow; and never missed any time from work due to right elbow problems, prior to January 31, 2007, was credible and unrebutted. The Arbitrator finds this to be competent evidence that Petitioner's right elbow was in good health prior to January 31, 2007.

The petitioner's treating medical records from Giese on February 1, 2007, also support a causal connection. Dr. Giese took a history from Petitioner that states, "This Pt is here after a fall down the stairs yesterday." Dr. Giese noted that Petitioner complained of right elbow and right shoulder pain and, upon examination noted that Petitioner exhibited a fair amount of swelling at the tip of the elbow.

The Arbitrator also notes that Petitioner was examined by Dr. Jablonsky on February 1, 2007. The history taken by Dr. Jablonsky states, "...she was walking to the parking garage when she slipped and fell directly on her right elbow." Dr. Jablonsky examined Petitioner and found evidence of a small abrasion on the tip of the olecranon and mild thickening of the olecranon bursa. Dr. Jablonsky also noted that Petitioner had sensitivity to light touch to the right elbow. The doctor's diagnosis of Petitioner's condition was right elbow contusion, with olecranon bursitis.

The Arbitrator notes that Dr. Jablonsky's diagnosis of Petitioner's condition on February 19, 2007 was still "right elbow contusion and olecranon bursitis." In the history recorded by Dr. Cohen on January 27, 2010, he states, "On January 31, 2007, approximately three years ago, she fell on the tip of her right elbow at work." Dr. Cohen noted that Petitioner was tender over the olecranon bursa and he

noted a slight defect in the bursa with a small loose body. Dr. Cohen diagnosed Petitioner with chronic olecranon bursitis with thickening of the bursa and a small loose body.

Petitioner testified at hearing that she still experiences heightened sensitivity and pain in her right elbow. In addition, Petitioner testified that she has not reinjured her right elbow since her work accident on January 31, 2007.

Accordingly, while the Arbitrator notes that a significant period of time has passed since her work injury on January 31, 2007, the medical records are clear that Petitioner has experienced consistent complaints of pain and sensitivity to the right olecranon since the day she fell. The Arbitrator recognizes that proof of the state of health of the Petitioner prior to and down to the time of injury, and then changes immediately following the injury and continuing thereafter, is evidence to establish that the impaired condition was due to the injury. *Spector Freight System, Inc. v. Industrial Commission,* 93 Ill. 2d 507, 513, 445 N.E.2d 280, 67 Ill. Dec. 800 (1983). Based on this analysis, the Arbitrator finds that Petitioner has proven, by a preponderance of the evidence that her current condition of ill-being, as it relates to her right elbow, is causally related to her work accident on January 31, 2007.

G. What were Petitioner's earnings?

The Arbitrator finds that Petitioner's earnings during the year preceding the injury were $73,477.97 and the Average Weekly Wage, calculated pursuant to Section 10 of the Act, was $1,469.56. The Arbitrator adopts Petitioner's credible and unrebutted testimony that she is a salaried employee of Respondent. Petitioner requested her pay records from Respondent and was provided with the records that have been admitted into evidence as Petitioner's Exhibit #10.

Upon review of Petitioner's pay records from the year preceding her injury, the Arbitrator finds that she earned $73,477.97 in non-overtime earnings over the 50 weeks Petitioner worked. Accordingly, the Arbitrator applies the second method of calculation of Petitioner's average weekly wage, as provided in Section 10 of the Act and divides Petitioner's non-overtime earnings of $73,477.97 by 50 which is the number of weeks worked by Petitioner in the year preceding the injury. The Arbitrator finds that this yields an Average Weekly Wage of $1,469.56 ($73,477.97/50 = $1,469.56). Based on the foregoing, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence, that her average weekly wage is $1,469.56, pursuant to Section 10 of the Act.

K. Is Petitioner entitled to any prospective medical care?

The Arbitrator finds that Petitioner is entitled to another examination by Dr. Cohen. The Findings of Fact and Conclusions of Law as stated above are adopted herein. The Arbitrator notes that Petitioner still complains of sensitivity in her right elbow that is similar to the symptoms she experienced when she was last evaluated by Dr. Cohen on January 27, 2010. At the time of that examination, Dr. Cohen specifically advised Petitioner that she would be a candidate for a bursectomy surgery with removal of the small loose body, should Petitioner's symptoms persist.

The Arbitrator finds that Petitioner has given her injury ample time to determine whether her symptoms would abate and as they have not; it is reasonable for Petitioner to return to see Dr. Cohen to determine if the surgery he recommended in 2010 is still an option for her, or, in the alternative, if there are other medical options available to her at this time. Further, the Arbitrator personally observed a bump on the tip of Petitioner's right elbow and a larger lump located approximately one inch from the tip of Petitioner's right elbow.

Based on the foregoing, the Arbitrator finds that Petitioner has proven, by a preponderance of the evidence that prospective medical care is reasonable and necessary treatment for Petitioner's condition of ill-being and should be provided by Respondent.

18IWCC0350

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
10WC3929
SIGNATURE PAGE

Signature of Arbitrator

January 20, 2017
Date of Decision

JAN 20 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jesus Leguizamo-Brito,

Petitioner,

vs. NO: 14WC 27219

18IWCC0351

Select Remedy,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, prospective medical care, notice, penalties and fees, 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 July 5, 2017 is hereby affirmed and adopted.

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

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

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

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 6 - 2018
MJB/sj
o-5/24/18
44

Michael J. Brennan

Deborah L. Simpson

David L. Gore

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

LEGUIZAMO-BRITO, JESUS
Employee/Petitioner

Case# **14WC027219**

SELECT REMEDY
Employer/Respondent

18IWCC0351

On 7/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

3042 LAW OFFICES OF HECTOR ESPITIA
415 N LASALLE ST
SUITE 300
CHICAGO, IL 60654

1886 LEAHY EISENBERG & FRAENKEL
JINAL PATEL
33 W MONROE ST SUITE 1100
CHICAGO, IL 60603

18IWCC0351

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
19(b) ARBITRATION DECISION

JESUS LEGUIZAMO-BRITO
Employee/Petitioner

v.

SELECT REMEDY
Employer/Respondent

Case # 14 wc 27219

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 T. CRONIN**, Arbitrator of the Commission, in the city of **CHICAGO**, on **MAY 2, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident, **August 1, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 of left hip contusion, sprain of the lumbar region and sprain of the neck *are* causally related to the accident.

In the year preceding the injury, Petitioner earned **$12,614.82**; the average weekly wage was **$260.02**.

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 **$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

Given the Arbitrator's findings and conclusions on the issue of causation, he denies Petitioner's claim for TTD benefits, medical bills and prospective medical care.

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

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

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

Signature of Arbitrator

7/5/17
Date

ICArbDec19(b)

State of Illinois)
) SS
County of Cook)

18IWCC0351

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JESUS LEGUIZAMO-BRITO	)	
	)	
Petitioner,	)	
	)	
v.	)	No.: 14 WC 027219
	)	Arbitrator: Brian Cronin
SELECT REMEDY,	)	
	)	
Respondent.	)	

19(b) DECISION OF ARBITRATOR

FINDINGS OF FACT:

Petitioner's Testimony:

Petitioner testified that he was graduated from a university in Mexico, that he is married and that he and his wife have a 15-year-old daughter and a 13-year-old daughter.

On August 1, 2013, Petitioner testified, he worked for Respondent as a packer at Rich Produce and earned $8.25 an hour. (T. 12 & 13). At 2:00 a.m., as he was walking down a hallway outside the cafeteria, he slipped, moved his body toward the left-hand side, tried to grab something, fell on his left side and felt that something in his arm "snapped". (T. 14). He testified that at the moment he fell, he struck his head. (T. 14). He testified that his neck "snapped", his chin struck his chest and his right leg fell to the ground, and struck the ground, the floor. (T. 15).

Petitioner further testified that when he said he heard something snap in his arm, he meant his right arm. (T. 15). The floor on which he fell had a tile surface. (T. 15). He testified that he had a loss of consciousness for more than five minutes. (T. 15).

Petitioner testified that he reported the injury to his shift supervisor named Jose Tagle of Rich Produce. (T. 16). He testified that he also reported the accident to Juan, who was the dispatcher for Select Remedy. (T. 18). He testified that he felt pain in his arm, his neck, his back and his leg. (T. 19). He further testified that such pain was in his right arm and right leg. (T. 20).

He testified that he was "checked out from head to toe" at U.S. HealthWorks, underwent x-rays, and was given medication for the pain. (T. 20). He testified that he returned to work with restrictions of seated duty. (T. 21). He testified that the he had a follow-up appointment at U.S. HealthWorks, at which time the doctor prescribed that he return to work without any restrictions. (T. 23). Petitioner was discharged from U.S. HealthWorks at this visit and returned to work at his regular shift. (T. 23). Petitioner testified that if he took the medication he was able to function and not be in pain, so he kept taking it for 2-1/2 months. (T. 24). He testified that when he stopped taking the medication, he began to lose mobility in his arm, had pain in his neck and his leg began to swell. (T. 24). He also testified that his lower back pain would not allow him to bend. Upon his attorneys asking, he clarified that he was talking about his right arm and right leg. (T. 25).

Petitioner testified that he was in the Emergency Room of Swedish Covenant in November of 2013 when his pain felt severe. (T. 25 & T. 26). He testified that he was given medication and advised to see a family practice physician at Erie Foster Clinic. (T. 26). He testified that he continued to work for Select Remedy at Rich Produce. (T. 26).

Petitioner testified that even at his November 2013 visit at Swedish Covenant, he was not given any work restrictions at all. (T. 27). He testified that he began seeing doctors at Erie Foster in December of 2013 but could not recall any specific names. (T. 27). He testified that doctors at Erie Foster placed him on work restrictions. (T. 27). He testified that his only work restriction was that he "could not carry anything heavier than 50 pounds." (T. 28). He testified he was able to work without issues as long as he kept taking the medication. (T. 29). He testified that he was terminated from Select Remedy in April of 2014. (T. 30). He testified that his termination was based on an e-verification which they reviewed; they said he did not have the proper work documents to work for Select Remedy. (T. 31).

Petitioner testified that the condition of his arm was worsening over time and he was prescribed an MRI by Dr. Williams. (T. 33). He testified that Dr. Williams reviewed the MRI and prescribed pills, physical therapy and injections for his arm. He testified that the injections, pills and physical therapy did not help his right shoulder and Dr. Williams recommended that he undergo an operation to his right arm. (T. 34).

Petitioner testified that he began treating with Dr. Younger after Dr. Williams left the practice. (T. 35). He testified that Dr. Younger advised him to take pain pills and get the operation. (T. 35). He testified that he began a new job through a temporary employment agency. (T. 35). He

testified that he received no workers' compensation or disability from Select Remedy. (T. 36). Dr. Younger gave him some further work restrictions until November of 2015, when he stated that he should remain off work. (T. 36 & T. 37).

Petitioner testified that at the present time, his right arm, neck and back hurt because he cannot be seated for a long time. (T. 37). He testified that he received medical bills from Swedish Covenant Hospital and Erie Foster which were sent to his residence and have been marked as Exhibit 12. (T. 38). Petitioner testified that the bills were invoices for the medical visits including the MRIs, X-rays and medical consultations. (T. 38). Petitioner testified that these bills have now been paid. He testified that he paid the bills at Erie Foster out-of- pocket and that they ranged from $35-$45. (T. 39). Petitioner testified that while there is a note in the medical record that he was involved in an automobile accident on November 1, 2013, he was not involved in one. (T. 40).

On cross-examination, Petitioner testified that he filled out a diagram of the body parts he injured, but would dispute what was filled out. (T. 45). He testified that "I do not recall exactly what it is that I indicated at that time". (T. 45). Petitioner testified that the diagnosis given to him on August 2, 2013 was that "nothing was wrong with him." (T. 47). When asked if Petitioner would dispute the medical records if they indicated that no right shoulder injury was mentioned, he answered "Yes." (T. 48). He also indicated that a Spanish interpreter was present on the initial visit and at the follow-up of August 6, 2013. (T. 48). When asked if he would dispute the medical records if they indicated that the only diagnosis was a contusion of the left hip, a lumbar region sprain and a neck sprain, Petitioner testified: "I do not understand why on the date of the medical report in the hospital they only wrote down those injuries." (T. 48-50).

Petitioner testified that some of his pain complaints must have been left out of the medical records from August 6, 2013. (T. 51). He testified that he would dispute the medical records "if they indicated that he was markedly improved and discharged form care without any restrictions." (T. 51). He testified again that he complained of a right shoulder injury at U.S. HealthWorks but has no idea why it is not marked in the diagrams or the medical records. (The diagrams he personally filled out) (T. 51 & T. 52). Petitioner testified that he had no medical treatment after his discharge on August 6, 2013 and that he was released from care. When asked about the medical records that indicated "neck and arm pain following a motor vehicle accident", Petitioner testified that he would dispute these records. (T. 53). He indicated that there was no car accident, despite the history provided to the medical practitioners. (T. 53). He said he would dispute the medical

records if they indicated that he had 'multiple episodes of pain and multiple sites mostly generalized body aches and tenderness." (T. 53-54). He testified that he was aware that it was not until 87 days after the date of accident where a right shoulder injury was mentioned in the records. (T. 54). He further testified that from August 6, 2013 through November 1, 2013, he received no medical treatment for all of the symptoms to the left extremity only. (T. 54). He indicated that he was working this entire time. (T. 54 & T. 55). Petitioner testified that while the records from August 1st, 2013 indicated left extremity pain, which was supported by the body diagram, where a Spanish interpreter was there to assist him, his complaints on and after November 1, 2013 were all for the right extremity. (T. 55). Petitioner testified that he told the doctors that on November 6, 2013, that he slipped and fell while grabbing a railing with his right hand. (T. 55 & T. 56). He testified that this was the same history he had provided in his original medical records and that if it was not recorded in those records, he would dispute those records. (T. 56).

Petitioner testified he does not recall a visit to Erie Foster on December 2, 2013, and he would dispute the medical records if they indicated that he sought treatment on this day. However, when asked the same questions again, he said he did visit Dr. Simon at Erie Foster on that day.

Petitioner testified that he recalled telling the doctor at Erie Foster on December 2013 that two weeks ago he had slipped on ice but never came to the hospital because he did not have a ride. (T. 58). He further testified that such a slip and fall on ice occurred on or about December of 2013, on the street near his house. (T. 59). He testified that he would dispute the medical records if they indicated he was diagnosed with back pain, sciatica and right foot pain on this visit. (T. 59 & T. 60)

Petitioner testified that he does not recall a visit in February of 2014 at Erie Foster and would dispute the medical records if they indicated he had a visit. He testified that he was not aware that he was released to full duty work in February of 2014. (T. 63). Petitioner testified that he was unaware that there was absolutely no medical documentation that indicated he had pain complaints to his right shoulder. (T. 64). He would dispute the medical records if a right shoulder injury was not documented on that day.

Petitioner testified that he would dispute the medical records if they indicated that he had two intervening accidents including a motor vehicle and a slip and fall before there was documentation of a right shoulder injury or pain. (T. 65) He testified that he did recall having an

MRI of the right shoulder and the cervical spine, but denied or did not recall that such tests were administered after the slip and fall and motor vehicle accident. (T. 65-66).

Petitioner testified that he was diagnosed with adhesive capsulitis and was given a steroid injection in January of 2015. (T. 66 & T. 67). He testified that he was working at a printing company at that point where he lifted up to 35 - 40 pounds overhead at a time. (T. 67). He testified that his right shoulder injury impacted his physical activities and hobbies. (T. 68). Petitioner testified that in Grant Park in June of 2015, he ran, walked, and jogged. He testified that he actively participated. (T. 69). He testified that he had shoulder pain but he was able to run, walk and jog. (T. 69). He testified that despite the recommendation for right shoulder surgery, he was working full time. (T. 70).

Petitioner testified that he does not recall that in June of 2015, Dr. Younger stated he would not recommend a capsular release since it appeared that Petitioner's pain was improving. (T. 70). He testified he would dispute the medical records if they indicated so. (T. 71). When asked if his other pain complaints to the foot and lumbar back had resolved by 2016, Petitioner testified "no," but stated that it was true that he was no longer treating for the foot, back or neck complaints.

Petitioner testified that he did not recall a visit with Dr. Younger on June 27, 2016, where he indicated he had been in yet another car accident. (T. 71). Yet, he then testified that he was in a car accident sometime in mid-June 2016. (T. 72). He testified that he was a passenger and was rear ended but had no pain complaints. (T. 72). He testified that he did not recall having any pain complaints even though he mentioned them in the medical records. (T. 72 & T. 73).

Petitioner testified that this was not his third intervening accident from the alleged date of accident. (T. 73). He further testified that despite all of these right-sided complaints, he was able to continue working for three years after the date of injury. (T. 73). Petitioner ended his testimony by stating that on August 1, 2013, he fell on the left side of his body. (T. 73 & T. 74).

On redirect examination, Petitioner testified that he does not know what the doctors write in his records and that he just goes to the doctor and tells them his complaints. (T. 75). He hopes that the doctors listen attentively and document everything correctly. (T. 75). Petitioner further testified that he did not go to Swedish Covenant Hospital on November 1, 2013 because he was involved in an auto accident, but because he had pain complaints from his slip and fall of August 1, 2013. (T. 76). Petitioner testified that for approximately 75 days, he took the pain medication prescribed by the doctor at U.S. HealthWorks. (T. 76). Petitioner further testified that after he

finished taking that medicine, he began to experience increased pain, which prompted him to seek treatment at the Swedish Covenant Hospital emergency room. (T. 77).

Medical Opinions:

Dr. Younger, Petitioner's treating physician, first examined Petitioner on December 14, 2015. At that time, Petitioner requested a translator for communication. (Px.4)

Dr. Younger testified that the history he used to base his opinion regarding this claim was from the December 2, 2014 record of Denis Williams, M.D. (Px.8, p. 37). The history provided in that record states: "His (sic) describes his whole right side being injured from shoulder to foot." (Px.4) Dr. Younger acknowledged that Dr. Williams dictated in his notes that Petitioner described his whole right side being injured from shoulder to foot. (Px.8, p. 37).

Dr. Younger was never provided with the August 2, 2013 records of U.S. HealthWorks of Illinois. In the deposition, Dr. Younger agreed that the records for such date never mentioned any right-sided pain involving the arm and may actually only point to left-sided pain, including the hip. (Id., p. 40). Dr. Younger further testified that the August 2, 2013 dictated report of the U.S. HealthWorks' physician indicates: "Patient states that he fell on his back on the left side". Dr. Younger agreed that there is again no mention of the word "right" throughout the entire physical examination. (Id., p. 42).

Dr. Younger also agreed that the diagnosis included a left hip contusion and that in order to have sustained a left hip contusion, one must have fallen on the left side. (Id., p. 44). He also agreed that the medical records from five days post-accident did not mention any right-sided complaints by Petitioner. (Id., p. 44).

Next, Dr. Younger reviewed the Swedish Covenant Hospital records from November 1, 2013. He noted that the upper portion of page one of such records states "neck and arm pain post motor vehicle accident." (Id., p. 45). Page one of such records indicates that he sustained an MVA at work on "06/04/13," and that he has no primary or family physician. (Rx.4, p. 1)

Dr. Younger testified that the July 2015 MRI of the right shoulder showed a traumatic shoulder separation, which is most definitely not what is listed on any of the medical records contemporaneous to the claimed date of accident. (Px.8, p. 54). Most significantly, Dr. Younger testified that it would be highly unlikely that a new onset of adhesive capsulitis, as interpreted by

Dr. Williams in the December 2014 right shoulder MRI, would have been caused by trauma from a year and a half prior. (Id., p. 58).

Dr. Mercier performed a Section 12 examination of Petitioner on February 4, 2016. He conducted a physical examination, through an interpreter, and reviewed all prior medical records before writing his report. (Rx.5).

Dr. Mercier testified that there is no mention of any right-sided body complaints by Petitioner to his doctors on August 1, 2013 or August 6, 2013. (Rx.6, p. 15). No shoulder injury and no right foot problems were noted either. Petitioner was diagnosed with a low back strain and left hip contusion only. (Id., pp. 15-16) By August 6, 2013, Petitioner was released to MMI with no restrictions, and in fact, resumed all regular duties. (Id., p. 16). Petitioner did not seek any further medical care until 87 days later, or approximately 3 months later, at Swedish Covenant Hospital. (Id., p. 16). Petitioner reported non-specific body pain with pain shooting into the right leg and foot. He was diagnosed with sciatica and prescribed an MRI. Dr. Mercier testified that there was again no mention of right shoulder pain. (Id, p. 17). On December 2, 2013, Petitioner indicated that he had hurt his right foot and right side of his body by slipping and falling on ice two weeks prior. (Id., pp. 17-18). Dr. Mercier testified that no medical care after August 6, 2013 was related to any claimed work accident. (Id., pp. 19, 22, 24, 26, 27). Dr. Mercier found that the December 2014 MRI of the right shoulder specifically showed that Petitioner had at some point had an anterior dislocation of the shoulder (a condition that Petitioner's treating physician Dr. Younger described as traumatic and memorable) and that the later February 2015 MRI of the right shoulder showed a "bony contusion," indicative of "another injury at sometime between the two MRIs." (Id., p. 25). Dr. Mercier believed that no testing or care after August 6, 2013 was related to the Petitioner's claims of a work accident on August 1, 2013. (Id., pp. 24, 26). Dr. Mercier testified that no further surgery or other care whatsoever is required for Petitioner. (Id., pp. 26-28).

CONCLUSIONS OF LAW:

In support of his decisions with regard to issues (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 the following facts:

The Arbitrator finds that on August 1, 2013, Petitioner sustained an accident that arose out of and in the course of his employment by Respondent. The Arbitrator further finds that Petitioner provided timely notice of such accident to Respondent.

Petitioner provided unrebutted testimony that at approximately 2:00 a.m. that day, he slipped and fell outside the cafeteria and was soon surrounded by his shift supervisor, the manager, a mechanic, a Jeep driver and the janitorial supervisor. Petitioner also provided unrebutted testimony that he notified Jose Tagle, the shift driver at Rich Produce, and Juan, the dispatcher at Select Remedy, of the slip and fall injury, and that he was told by Juan to seek medical treatment at U.S. HealthWorks of Illinois. Although Petitioner testified he sought treatment on the day of the accident, the records of U.S. HealthWorks of Illinois indicate that Petitioner first received treatment at 5:55 p.m. on August 2, 2013, and further indicate that he sustained an injury when he slipped on water on the floor at the job site early on August 1, 2013. On August 6, 2013, Petitioner followed up with U.S. HealthWorks of Illinois for complaints related to the slip and fall.

The Arbitrator finds that any condition other than a contusion of his left hip, a sprain of the lumbar region and a sprain of the neck is not causally related to the accident of August 1, 2013.

In weighing the evidence, the Arbitrator places great weight on the August 2, 2013 and August 6, 2013 treating records, which are the initial treating records. (Px.1) Such records are from U.S. HealthWorks of Illinois and are devoid of any right-sided complaints, notwithstanding the fact that a Spanish interpreter was present. At the follow-up visit of August 6, 2013, Lynsey Keach Stewart, M.D., noted that Petitioner was markedly improved and discharged him from her care. Dr. Stewart instructed Petitioner to continue Naproxen and ice until the pain resolves, and released him to return to work with no restrictions, effective immediately. Dr. Stewart's discharge diagnosis is as follows: CONTUSION OF HIP L, SPRAIN LUMBAR REGION, SPRAIN OF NECK.

The Arbitrator also considers the fact that Petitioner did not seek additional treatment until November 1, 2013, which was 87 days after the accident, when he visited the emergency room at

Swedish Covenant Hospital. Such records indicate that Petitioner reported he had sustained injuries as the result of a motor vehicle accident five months ago and also indicate he reported he had sustained injuries as the result of a slip and fall at work five months ago.

The Arbitrator takes judicial notice that five months prior to November 1, 2013 was June 1, 2013.

On November 1, 2013, upon examining Petitioner, Joseph Youkhana, M.D., found multiple points of tenderness, especially the upper back, neck, thighs, hip, elbows and knees. (Rx.4) Such records from Swedish Covenant Hospital indicate that an interpreter was used. (Rx.4)

To Charlie Travers, R.N., Petitioner reported that following the slip and fall at work 5 months ago, he has had pain to his head, right arm, and right leg, which was controlled by medication until he ran out of it 1 month ago. (Rx.4)

To Juan Vargas, R.N., Petitioner stated that his "RIGHT FOOT IS SWOLLEN FROM THE FALL THAT HAS NOT RESOLVED." (Rx.4)

Petitioner testified that he recalled telling the doctor at Erie Foster on December 2, 2013 that two weeks ago he had slipped on ice but never came to the hospital because he did not have a ride. (T. 58). When asked what body parts were impacted from this fall, he replied: "None". (T. 59). The Erie Foster medical record indicates that his neck was affected by the fall. (Px.3)

When asked on cross-examination if the other pain complaints to his foot and lumbar back had resolved by 2016, Petitioner testified "No," but then indicated it is true that he no longer treats for his foot, back or neck complaints. (T. 71).

Furthermore, the doctors found that Petitioner had a Hill-Sachs lesion in his right shoulder, which indicates a prior right shoulder dislocation. Yet, Petitioner denied that he ever dislocated his right shoulder.

The Arbitrator finds that Petitioner is simply not credible.

Moreover, the Arbitrator finds, in this case, that the opinions of Charles W. Mercier, M.D., are more persuasive that those of Terry I. Younger, M.D.

Both physicians are orthopedic surgeons.

Dr. Mercier conducted a Section 12 examination on behalf of Respondent and testified that 99% of the IMEs he conducts are for the defense. Dr. Mercier initially opined that no one knows what causes adhesive capsulitis, but then testified that trauma didn't cause the adhesive capsulitis. (Rx.6, p. 41).

Dr. Mercier testified that when he examined Petitioner, he specifically asked him when he developed neck, right shoulder, low back and right foot pain. Petitioner stated that he developed all these symptoms before seeing the doctor on August 2, 2013, and stated that they were the result of the alleged events on August 2, 2013, but that when he went to see the doctor on August 2, 2013 at U.S. HealthWorks, he only had pain in his neck and the left side of his low back. (Rx.6, p. 14).

Finally, Dr. Mercier testified that Petitioner sustained a bone contusion, and thus a new injury, between the two sets of MRIs that were taken of the right shoulder.

Dr. Younger testified that he relied on the history Petitioner gave to Dr. Williams on December 2, 2014, and that prior to Dr. Younger's deposition, he had not reviewed the August 2nd and 6th, 2013 records from U.S. HealthWorks or the November 1, 2013 records from Swedish Covenant Hospital. Although Dr. Younger testified that there was a significant language barrier with Petitioner, and although he testified that he first spoke with Petitioner's attorney on the date of such deposition, Dr. Younger wrote, in his June 27, 2016 office visit note, the following: "Patient continues to work with his attorney regarding causation of this case. Patient was counseled to have his attorney contact me for information."

The Commission is not required to give more weight to the opinion of a treating physician than that of an examining physician. *Prairie Farms Dairy v. Indus. Comm'n*, 279 Ill. App. 3d 546, 550 (5th Dist. 1996)

Given the Arbitrator's findings and conclusions on the issue of causation, he denies Petitioner's claim for TTD benefits, medical bills and prospective medical care.

Brian T. Cronin
Arbitrator

7-5-2017
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

Kevin J. O'Driscoll,

Petitioner,

vs. NO: 08WC054233

City of Chicago – Department of Aviation, 18IWCC0352

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 6, 2017, is hereby affirmed and adopted.

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

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 6 – 2018
MJB/sj
o-5/24/18
44

Michael J. Brennan

Deborah L. Simpson

David L. Gore

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

O'DRISCOLL, KEVIN J
Employee/Petitioner

Case# **08WC054233**

06WC035206

CITY OF CHICAGO-DEPT OF AVIATION
Employer/Respondent

18IWCC0352

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

If the Commission reviews this award, interest of 1.07% 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:

1497 MORICI FIGLIOLI & ASSOCIATES
DAVID FIGLIOLI
150 N MICHIGAN AVE SUITE 1100
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY
ROBERT F DELANEY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

18IWCC0352

☒ 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)

KEVIN J. O'DRISCOLL,
Employee/Petitioner

Case # **08 WC 54233**

v.

Consolidated cases: **06 WC 35206**

CITY OF CHICAGO - DEPARTMENT OF AVIATION,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DAVID KANE**, Arbitrator of the Commission, in the city of **CHICAGO**, on various dates between **May 2014 and March 27, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0352

FINDINGS

On the date of accident, 10/31/2008, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $76,752.00 and the average weekly wage was $ 1,476.00.

On the date of accident, Petitioner was **48** 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 $ 273,600.00 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $ 273,600.00 .

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

ORDER

Denial of benefits

No benefits are awarded.

Penalties

Petition for 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.

David A. Kane
Signature of Arbitrator

June 6, 2017
Date

ICArbDec19(b)

JUN 6 - 2017

STATE OF ILLINOIS)
) ss.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin J. O'Driscoll

Petitioner,

v.

City of Chicago - Department of Aviation

Respondent.

Court No. 08 WC 54233
Consolidated cases: 06 WC 35206

MEMORANDUM OF ARBITRATOR'S DECISION

Kevin O'Driscoll (hereinafter "Petitioner") worked as a painter for Chicago Department of Aviation (hereinafter "Respondent") on October 31, 2008. He worked at O'Hare Airport and was working in a below-ground tunnel on a ladder. The Petitioner reported that the ladder collapsed and caused Petitioner to fall to the ground. The Petitioner alleged that he landed feet first and felt a pop in the right ankle. Petitioner ultimately landed on his hip. The accident was not witnessed.

Petitioner was able to get in touch with supervisor Kirk Woelfe who came to get the Petitioner. An incident report was filled out. Petitioner did have a prior right foot injury at work on March 30, 2006, but had returned to work full duty by July 25, 2007. Petitioner denied any prior injury or

treatment to either hip.

Petitioner was taken by his supervisor on October 31, 2008 to Mercy Works for treatment. His complaints included the right ankle, left hip and low back. Treatment commenced which included taking Petitioner off work. He was ambulating on crutches afterward.

Petitioner came under the care of Dr. Vargo, who performed surgery on the right foot on January 13, 2009.

Dr. Matthew Jimenez simultaneously treated the left hip. Dr. Jimenez later performed left hip surgery on January 18, 2010. The Respondent disputed payment for that treatment.

Petitioner has continued to undergo treatment off and on since the 2008 accident date and has not returned to work. Dr. Jimenez released the petitioner without restriction in regard to the left hip, but Dr. Vargo kept him on restrictions for the feet and ankles. The Respondent paid compensation up until a dispute arose early in 2014. The Petitioner did complete an FCE that indicated a 50-pound lifting restriction, limitation of one hour for walking, and no use of ladders.

Multiple independent medical examinations were obtained by the Respondent, the initial exam by Dr. Joshua Jacobs on 10/19/09 and all subsequent examinations by Dr. Armen Kelikian. The IME reports were consistent with the views of medical providers until the last addendum report from Dr. Kelikian on 3/19/14. The report included the doctor's evaluation of numerous surveillance tapes involving the Petitioner's activities. Dr. Kelikian disclosed that the Petitioner's activities shown to him were inconsistent with his prior opinions about the Petitioner's condition and limitations (RX 4).

Respondent offered several witnesses, including Petitioner's spouse

and work supervisor. Two neighbors also testified. Private investigators offered videotape depicting Petitioner's activities.

The Petitioner lost his driver's licenses in the 1990s but admitted that he drove on occasions without a license. He claimed that his driving was limited to taking his son to school or to get to the store. He denied that he had driven for several months when the trial got started. He agreed that near the time or these proceedings he was pulled over and arrested for driving on a revoked license. He ultimately pleaded guilty to a felony charge.

Surveillance evidence was offered by Respondent from numerous occasions, including tape of the Petitioner driving his motorcycle and stopping at a gas station to put a Blacks Hawk memorabilia that was attached to his motorcycle at that time the Chicago Black Hawks were celebrating one of their championships in 2013.

Petitioner admitted to shoveling snow especially in the harsh winter of 2013-14. He described he would use a shovel on the front sidewalk and a snow blower on a long driveway. Surveillance taken by his neighbor, Russ Bacius, shows him using a shovel at all times.

Petitioner had another accident on September 23, 2007, when he reported falling down stairs at home. That incident seems unrelated to this matter except for testimony that the Petitioner was actually injured on that date when he was riding a motorcycle which crashed and, further, that the event was the cause of any ongoing medical problems. Petitioner testified similarly to what he told doctors at Lutheran General Hospital that he fell down stairs. The Petitioner admitted that he drove his motorcycle that day and that it became necessary to have the motorcycle towed from the Kennedy Express that evening but denied driving it at that time. He claimed

a friend used his motorcycle and ran out of gas on the expressway.

The Petitioner's estranged spouse, Paula O'Driscoll, testified and denied the Petitioner allegation of falling down stairs at home. She related that he left earlier in the day and was riding his motorcycle. She related that she received a phone call to pick the Petitioner up from near the expressway that day and found him injured. After arriving home it was apparent the injuries were serious so they drove to Lutheran General Hospital where the Petitioner gave a history of falling down stairs. She did not intercede to correct the history as she did not want to cause a scene in the emergency room. Paula O'Driscoll testified that she was testifying against the Petitioner even though it could interfere in an award of benefits that would be an advantage for her and their minor son. Paula O'Driscoll testified about seeing Petitioner ambulate without difficulty or need for a cane in 2013 which was the last full year they lived together. The Petitioner did not appear with a cane during multiple hearings in 2014 and 2015 but did appear with a cane during the last few hearings.

Paula O'Driscoll also testified that she frequently saw the Petitioner drive without a driver's license. Petitioner admitted that he rode his motorcycle on September 23, 2007, but claimed he loaned the motorcycle to a friend and was home later in the day when he fell down stairs. The Petitioner testified that his friend ran out of gas on the motorcycle which meant the vehicle had to be towed. Towing records from September 23, 2007, were offered that showed the Petitioner's vehicle was towed from the Kennedy Expressway and then stored for three days before it was returned to Petitioner's home by flatbed tow. The initial towing record from Village Auto Body & Towing checked accident as the reason for the job.

A neighbor, Russ Bacius also testified and described a conversation

with the Petitioner outside his house in October of 2013 during which the Petitioner brought up a disability claim with the city that was no longer being disputed. Bacius testified that Petitioner told him he was fine but that he had crashed his motorcycle when he was drunk in the past, but was still faking an injury to stay off work. Russ Bacius testified that he was bothered by the Petitioner's admission that he was getting workers' compensation benefits he should not be getting. He complained initially to the Petitioner and later tried to initiate an investigation by the Chicago Inspector General's office.

The Petitioner alleged his neighbor Bacius had a grudge against the Petitioner and even threatened to kill the Petitioner and Petitioner's son. Petitioner filed a complaint with the police department which was reportedly ongoing whereas Bacius testified the investigation was closed and provided a notice from the agency's internal affairs to that effect.

Petitioner offered no evidence or testimony to suggest a spat prior to October of 2013. The Petitioner described an incident of an injury by another policeman who lived in the Bacius house but did not call an Internal Affairs investigator to back up some story about this other police office being investigated. Bacius and the Petitioner were neighbors for approximately five years. Bacius described the relationship as friendly up until the time of a conversation where the Petitioner allegedly described fabricating a claim under workers' compensation, with Bacius criticizing his neighbor for doing so.

Both Connie Bacius and Russ Bacius testified against the petitioner, their next-door neighbor. Both denied any history of problems with the petitioner before 2013. Connie Bacius described a time in the spring of 2013 when the Petitioner borrowed the Bacius' air compressor to blow up

his children's pool. She also testified about the Petitioner's lengthy history of alcoholic consumption.

Petitioner says and his medical records indicate that he fell down stairs at home in 2007. The petitioner's estranged spouse, Paula O'Driscoll, testified that instead she was called the date of that injury and told to pick the petitioner up from along the Kennedy Expressway. She took him home but then changed course to the hospital when realizing he was too injured to make it from their vehicle to their home. Paula O'Driscoll disputed that the petitioner fell down stairs at home that day and that she found him injured where she was told to pick him up.

Petitioner's neighbor, Russ Bacius, testified as to a conversation in October of 2013 where Petitioner expressed some jubilation and then explained that he was "free of the city." He explained that the city had accepted his injury claim. Bacius asked further and was told Petitioner was really injured in a motorcycle accident in 2007 but was no longer hurt. He was faking the injury to continue to receive benefits from the employer. Bacius attempted to file a complained with the city's inspector general and began videotaping the Petitioner's activities. He did so because he disagreed with the Petitioner faking an injury to get benefits.

There was also evidence concerning the Petitioner's attempts to have a driver's license re-instated or, alternative, a work permit to drive to and from work. A hearing occurred in 2013 where the Secretary of State denied reinstatement of a driver's license but at least preliminarily issued a work permit. That was based on a work verification that was presented to the Secretary of State describing the Petitioner's employment for the Chicago Department of Aviation and work hours seven days a week. The Respondent offered two versions of the Employment Verification form. The

first showed the printed name of a supervisor at Chicago Aviation by the name Manny Zeleya. The second accompanied by a letter from the Secretary of State explained the process of keeping records with this being the best version of the document available. It shows the supervisor's printed name and the top portion below of what could be a signature. Paula O'Driscoll testified that she saw original copies at her home with the Petitioner that had the supervisor's printed name and a signature. The Petitioner testified that he filled out the employment verification form and printed a supervisor's name. He denied there was a signature. The Respondent called Manny Zelaya to testify concerning the document. He denied filling out the form or knowing anything about it. He related that an investigator from the Illinois Secretary of State met him at work to question him about the employment verification document.

The Petitioner testified that he has not work since 2008 but contended that he requested the work permit and offered the employment verification document because he continued to hope the Respondent would accommodate his restrictions. He also admitted the employer told him they would never be able to accommodate work restrictions with his job.

Petitioner offered contradictory testimony during a rebuttal hearing in this case. He testified at the beginning of the case that he cleared snow at home with either a snowblower the driveway and a shovel on the sidewalk. During rebuttal testimony he denied that he used a snow blower and testified on that occasion that he hired a service to clear snow. He also contradicted prior testimony on the manner he used for hanging Christmas ornaments such as wreaths. He initially testified that he probably used an extension ladder to hang them. At the rebuttal hearing he described using a six-foot ladder.

The Petitioner offered testimony about the frequency of telephonic communications between the Bacius' and his wife. The contacts occurred over a period of years between next-door neighbors and the nature of the communications was not disclosed.

The Petitioner testified during rebuttal that witnesses describing that he rarely used a cane were wrong. None of the surveillance videotape filmed by either Russ Bacius or private investigators showed the Petitioner with a cane.

Respondent presented evidence that despite the Petitioner's doctor restricting him from use of a ladder, which is one of the job requirements, the Petitioner does use a ladder at home including an extension ladder that he lifted, carried, and climbed when he installed a home-security system on the outside of his home. The ladder appeared to be at least fifteen feet in height. The Petitioner lifted and moved the ladder from location to location. He then climbed the ladder and leaned off to the side as he installed wiring to his house.

Surveillance film showed petitioner on a golf course. He is seen riding in a golf cart with another individual and two sets of golf clubs. He is seen walking on the green, though he is not shown driving a golf ball or hitting on the fairway. The Petitioner claimed that he had one standing golf event every Fourth of July weekend but only putted when he was on the course. He did not explain why he would bring a complete bag of clubs if he only used one or two clubs. Petitioner's neighbor, Russ Bacius, testified that he saw the Petitioner leave with golf clubs several times a year and also practicing hitting a golf ball in his backyard using various clubs.

CONCLUSIONS OF LAW

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

A petitioner's credibility is essential to secure workers' compensation benefits, particularly where a dispute concerning the accident has arisen. If the underlying facts do not support a petitioner's Application and request for benefits the Commission should properly deny benefits. Docksteiner v Industrial Comm'n, 346 Ill.App.3d 851, 282 Ill.Dec. 255 (2004).

Following a lengthy hearing and multiple witnesses, the Respondent's evidence has effectively destroyed any ability for the Petitioner in this case to argue he has a credible claim for benefits. The Petitioner's lack of credibility goes far beyond video evidence of his activities that are contrary to what he wants his medical providers and the Arbitrator to believe. The Petitioner's actions time after time showed he was not trustworthy and had no moral compass to abide by the simplest of rules. The Arbitrator believes the Petitioner falsified a driver's license application to the Illinois Secretary of State to secure driving rights and represented that the request was sanctified by his employer despite the fact that he has not worked in more than six years. He then chose to drive on unknown number of occasions despite not having an active job when he received a limited work permit. Just before this trial got underway he was arrested one occasion for a felony charge of driving with a revoked license and pleaded guilty.

He falsely told medical doctors that he was injured from a fall down

stairs at home when he instead was injured while illegally driving his motorcycle and crashing. The Arbitrator is unpersuaded by Petitioner's account that he loaned his motorcycle to a friend who ran out of gasoline on the Kennedy Expressway.

Evidence that the Petitioner drove his motorcycle, including the Petitioner's own admissions, contradicts his testimony that he drove without a license for very limited purposes including to take his son to school.

Connie Bacius was among numerous witnesses for the Respondent who lived next door and was able to observe the Petitioner on a regular basis. She testified that she did not observe any behavior by the Petitioner to suggest a significant injury.

Paula O'Driscoll, the Petitioner's estranged spouse, also testified though the testimony was limited by objections under spousal privilege which meant her testimony was limited to what she observed about the petitioner and what he said in the presence of others. Paula O'Driscoll persisted in her testimony that the petitioner was not injured at the time or trial or does he need benefits. Although the Petitioner raised a valid concern that Paula O'Driscoll was involved in a disputed divorce and child custody case at the time of her testimony, it is also without dispute and as Paula O'Driscoll testified that she and her son would financially benefit from the Petitioner obtaining benefits from this hearing. Paula O'Driscoll was perceived as a witness with no motive other than to testify truthfully about the Petitioner's condition as she observed it.

Most critically, the Petitioner related during a conversation with a neighbor who was also a Chicago police officer that he was pursuing a dishonest claim and was not actually injured or disabled from working. After understanding the mistake he made to discuss this with a police officer the

Petitioner then falsely reported a threat the neighbor made to harm the Petitioner and his son to undermine Russ Bacius' credibility when it was apparent he could testify about a fraudulent claim. The allegation of Bacius making a death threat is implausible, especially given the Petitioner offered no history of bad blood between the neighbors to explain such an event. The Petitioner did not even speculate about a possible motive for his neighbor to make such a threat. Up until that time they had lived as friendly next-door neighbors who occasionally socialized together. What changed was a casual conversation where the petitioner disclosed something that he thought better of afterward.

The Petitioner never offered any reasonable justification that a police officer would appear at the Petitioner's workers' compensation hearing and commit perjury by describing a fraudulent claim. The testimony does not benefit Bacius. If Bacius and others intended to assist the Petitioner's spouse in divorce or child custody proceedings as the Petitioner speculated throughout the hearing the logical action would have been to testify in those proceedings.

The Arbitrator also notes that given the extended time to complete the hearing the Petitioner had ample opportunity to present additional witnesses such as golf partners or a friend who used his motorcycle in rebuttal of the Respondent's case. Although the Petitioner testified himself he offered no other witnesses such as golf companions to verify his account of limited activities on a golf course when video showed him on the course with a full set of golf clubs while he claimed to use only a couple clubs to drive the ball or putt. He believed he cooperated with investigators into an accident involving his neighbor's housemate but failed to call any such investigator to verify this alleged history. The importance of the

Petitioner's credibility at this of these proceedings should have resulted in the Petitioner calling any corroborating witness he had available to buttress his case against the allegations against him. There were off-the-record conversations with the Arbitrator about the Petitioner producing a witness to challenge the credibility of the Respondent's witnesses, but none was offered.

The Respondent offered convincing evidence that the Petitioner was illegally driving his motorcycle when it crashed on September 23, 2007, which further means he falsified statements to medical doctors about the injuries. The contention that a friend borrowed the motorcycle and ran out of gas on the Kennedy Expressway is not credible. In the end

, if the Petitioner could not act truthfully with the Illinois Secretary of State about his work status or his own medical providers this Arbitrator finds it impossible to believe the Petitioner's testimony during these proceeding where he has such an obvious bias. The Arbitrator does not have to speculate as to the Petitioner's motives. He described them to Russ Bacius as wanting to falsify an injury and secure benefits while remaining off work.

The Petitioner throughout the hearing attacked Bacius and claimed he remained under investigation for threatening to kill the petitioner despite internal affairs at the Chicago Police Department issuing a decision before the start of the trial that the charge was not substantiated. The Petitioner's account of that ongoing investigation also turned out to be another falsehood.

The Arbitrator found Russ Bacius to be the most credible of the witnesses over the course of the hearing with no discernable reason to testify falsely against the Petitioner in a workers' compensation hearing and

jeopardize his career by doing so. He reacted to the Petitioner's admission of falsifying this claim precisely how a police officer would, which is to attempt to make a report about it and then to gather evidence about it.

For all of these reasons, the Arbitrator concludes that despite the medical evidence offered by the Petitioner that no accident occurred at work on October 31, 2008. The Arbitrator declines to award benefits. The Respondent is awarded a credit for any benefits paid since that date.

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

Compensation is hereby denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin J. O'Driscoll,

Petitioner,

vs. NO: 06WC035206

City of Chicago – Department of Aviation, **18IWCC0353**

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 6, 2017, is hereby affirmed and adopted.

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

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 6 - 2018
MJB/sj
o-5/24/18
44

Michael J. Brennan

Deborah L. Simpson

David L. Gore

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

O'DRISCOLL, KEVIN J
Employee/Petitioner

Case# **06WC035206**

08WC054233

CITY OF CHICAGO-DEPT OF AVIATION
Employer/Respondent

18IWCC0353

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

If the Commission reviews this award, interest of 1.07% 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:

1497 MORICI FIGLIOLI & ASSOCIATES
DAVID FIGLIOLI
150 N MICHIGANAVE SUITE 1100
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY
ROBERT F DELANEY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

18IWCC0353

- [ ] 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)

KEVIN J. O'DRISCOLL,
Employee/Petitioner

Case # **06 WC 35206**

v.

Consolidated cases: **08 WC 54233**

CITY OF CHICAGO - DEPARTMENT OF AVIATION,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DAVID KANE**, Arbitrator of the Commission, in the city of **CHICAGO**, on various dates including **5/22/2014, 6/24/2014, 8/8/2014, 12/16/2015, 3/25/2016, 8/30/2016 and 5/23/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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 [x] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

The Arbitrator finds that all benefits owed in regard to a claim of injury on March 30, 2006 have been paid and benefits for the period beginning 10/30/2008 are not causally related to this date of accident but will be addressed in a Decision for Case No. 08 WC 54233. Throughout the 19(b) proceedings the Petitioner related benefits sought in the current hearing to an alleged injury at work on October 30, 2008. Just before proofs were closed and after multiple witnesses had testified the Petitioner sought to amend the Request for Hearing forms to argue for ongoing TTD, maintenance and medical benefits under Case 06 WC 35206 and an accident date of March 30, 2006, rather than solely in connection to an accident date of October 30, 2008. No additional medical evidence from treating doctors to causally relate the current condition to the accident on March 30, 2006, was offered.

No additional benefits are awarded in regard to Case 06 WC 35206.

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

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

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

David A. Kane
Signature of Arbitrator

June 6, 2017
Date

ICArbDec19(b)

JUN 6 - 2017

18IWCC0353

STATE OF ILLINOIS)
) ss.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin J. O'Driscoll

Petitioner,

v.

City of Chicago - Department of Aviation

Respondent.

Court No. 06 WC 35206
Consolidated cases: **08 WC 54233**

MEMORANDUM OF ARBITRATOR'S DECISION

This is the first of two injuries involving the Petitioner. The second occurred on October 31, 2008. Both were heard before Arbitrator David Kane in a 19(b) hearing that began on May of 2014 and was concluded on May 23, 2017. The injury that occurred in 2006 has no bearing on the issues in that hearing and the decision over disputes are addressed in the decision in Case 08 WC 54233. At the conclusion of the hearing on May 23, 2017, the Petitioner was allowed to amend the Request for Hearing form to allege that all TTD and maintenance benefits through the date of hearing were being claimed for the date of injury in 2006. The Arbitrator finds otherwise that the benefits that may be owed from 2008 through the time of hearing are not causally related to the injury that occurred in 2006.

The Arbitrator notes that the Petitioner was released back to full duty after treatment in 2006 for this matter. The Petitioner was off work for an unrelated injury in September of 2007, and again was released back to work full duty. Up until the last date of hearing when proofs were closed and all witnesses had completed their testimony the Petitioner raised the contention for the first time that the current condition and need for benefits was causally related to the accident on March 30, 2006. No medical evidence from any treating doctor was offered to support this change in theory on causation of the current 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Angell,

Petitioner,

18IWCC0354

vs.

NO: 15 WC 11431

Chicago Heights School District #170,

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, notice, causal connection, medical expenses, temporary disability, and the nature and extent of the injury and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a 56-year-old school custodian, alleged work-related injuries to both hands manifesting on January 27, 2015. Petitioner underwent bilateral carpal tunnel releases in July and August of 2015 and bilateral thumb surgeries in November 2015 and February 2016. Respondent accepted liability for Petitioner's carpal tunnel syndrome but denied liability for Petitioner's thumb condition. The Arbitrator found that Petitioner met his burden of proving that both conditions arose out of his employment and awarded benefits under the Act for lost time, medical expenses, and permanent partial disability. After considering all the evidence, we find that Petitioner's employment did not cause or contribute to his thumb condition and we vacate the Arbitrator's award of benefits. We affirm the Arbitrator's Decision with respect to Petitioner's bilateral carpal tunnel syndrome.

We find that a preponderance of the evidence shows that Petitioner's thumb condition arose out of a personal medical condition. The record shows that in 2009 Petitioner began treating with Dr. Coats for thumb complaints that began a year earlier. Petitioner was diagnosed

with bilateral thumb CMC joint arthritis. Petitioner began receiving therapeutic injections and discussing surgery with his treating physician in early 2010. At the time, Petitioner reported that he wished to defer thumb surgery as he had recently been off work for knee surgery. Petitioner complained of difficulty using his hands with any activity. On February 11, 2013, Petitioner asked his treating physician, Dr. Coats, for an opinion on causal connection between his work duties as a janitor and his diagnoses of thumb CMC arthritis and carpal tunnel syndrome. Dr. Coats opined that Petitioner's employment was an "exacerbating factor" in both diseases, with an argument for causal connection being "slightly more compelling" with respect to carpal tunnel syndrome than for thumb CMC arthritis. Although Dr. Coats noted that Petitioner worked as a janitor, there is no evidence that Dr. Coats had a thorough understanding of Petitioner's job duties.

A claimant may be entitled to benefits under the Act even though he suffers from a preexisting condition, however the employee must show that the employment aggravated or accelerated the preexisting condition such that the employee's current condition of ill-being is causally connected to the employment and not simply the result of the normal degenerative process of the preexisting condition. At hearing, Petitioner testified that he was unable to recall much of his history of treatment for his thumbs prior to the alleged manifestation date, although he did not have any reason to disagree with the medical records in evidence. He agreed that he recalled making complaints to Dr. Coats about aggravation of his thumbs from playing video games. He agreed that he used to play video games, ride motorcycles, shoot guns, and smoke. The records show continuous treatment for thumb complaints going back to 2009, with repeated injections and several surgical recommendations prior to the alleged manifestation date in this claim. Petitioner testified that the symptoms in his thumbs and hands came on gradually and increased over time, but by January 27, 2015 he "just couldn't take it anymore" although he was able to continue working his regular duties.

Petitioner testified that he worked for Respondent as a custodian for 23 years. He was responsible for cleaning and maintenance of the school. He was required to lift and carry tables and chairs, to use equipment such as a broom, mop, vacuum, and floor buffer, and to use hand tools. Some duties were performed daily, while other duties such as stripping and waxing floors were performed only occasionally. Respondent offered into evidence a video of Petitioner performing some of his job duties, such as sweeping around the lunch room tables, taking out the garbage, installing a soap dispenser, and repairing a vacuum cleaner. Petitioner's job duties are hand-intensive, but there is no evidence of any job duties involving repetitive or sustained stress on his bilateral thumb joints. We find that Petitioner's thumb condition is attributable solely to the degenerative process of the preexisting condition for which he has treated continuously since 2009. We find no evidence directly linking Petitioner's bilateral thumb arthritis and his need for thumb surgery to an alleged work-related repetitive trauma injury. Therefore, we vacate the Arbitrator's award of benefits under the Act with respect to the thumbs and otherwise affirm the Arbitrator's decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $884.66 per week for a period of 2 and 1/7 weeks from July 24, 2015 through July 27, 2015 and from August 28, 2015 through September 7, 2015, that being the period of temporary total incapacity for work under §8(b) of the Act.

18IWCC0354

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 52.625 weeks, as provided in §8(e)9 of the Act, because the injuries sustained caused the 12.5% loss of use of the right hand and 15% loss of use of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary costs for medical expenses for treatment related to the non-disputed bilateral carpal tunnel syndrome, pursuant to §8(a) and 8.2 of the Act and the applicable fee schedule.

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

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

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 - 2018
DLS/plv
o-5/17/18
46

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

18IWCC0354

ANGELL, WILLIAM
Employee/Petitioner

Case# **15WC011431**

CHICAGO HEIGHTS CUSD #170
Employer/Respondent

On 7/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0317 LAW OFFICES OF PERRY M LAKS
205 W RANDOLPH ST
SUITE 1750
CHICAGO, IL 60606

2337 INMAN & FITZGIBBONS LTD
LAUREN L WANINSKI
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

18IWCC0354

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 ARBITRATOR DECISION

William Angell
Employee/Petitioner

v.

Chicago Heights CUSD #170
Employer/Respondent

Case # **15** WC **11431**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **February 17, 2017 and May 11, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 27, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitione*r did* sustain an accident that arose out of and in the course of employment. For the reasons set forth in the attached decision, the Arbitrator views January 27, 2015 as an appropriate manifestation date.

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

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

In the year preceding the injury, Petitioner earned $**69,003.48**; the average weekly wage was $**1,326.99**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **1** dependent child.

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

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

Respondent shall be given a credit of $**1,938.38** for TTD, per RX 14 and the parties' stipulation, along with credit for the full salary it paid during some of the period during which the Arbitrator has found Petitioner to be temporarily totally disabled, per the paychecks in RX 8.

The parties agree Respondent is entitled to a credit of $**29,224.13** under Section 8(j) of the Act for medical benefits paid by Blue Cross Blue Shield, with Respondent holding Petitioner harmless against said payment. Arb Exh 1. The Arbitrator finds that Respondent is also entitled to Section 8(j) credit for the $12,737.00 in IMRF payments established by RX 9 and Beth Clark's testimony.

ORDER

Respondent shall pay Petitioner the following reasonable and necessary medical expenses, subject to the fee schedule: Premier Orthopaedic (Dr. Labana), $17,362.75 and St. James Hospital, $14,798.43 (surgery of 11/16/15) and $17,637.53 (surgery of 2/29/16), with Respondent receiving Section 8(j) credit in the amount of $29,224.13, as stipulated (Arb Exh 1), and holding Petitioner harmless against said payment.

Respondent shall pay Petitioner temporary total disability benefits in the amount of $884.66 per week during the following three intervals: 7/24/15 through 7/27/15, 8/28/15 through 9/7/15 and 11/16/15 through 7/4/16. These three intervals total 35 2/7 weeks. The awarded benefits total $31,215.86 ($884.66 x 35 2/7). Per the parties' stipulation (Arb Exh 1, as amended), Respondent is entitled to credit in the amount of $1,938.38 for the temporary total disability benefits it paid via check (RX 14) on September 15, 2015. The Arbitrator finds Respondent is also entitled to credit for the full salary it paid during part of the 35 2/7 weeks, per RX 8.

Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 23.75 weeks, because the injuries sustained caused the 12.5% loss of use of the right hand (calculated at a 190-week value), as provided in Section 8(e)(9) of the Act. Respondent shall also pay Petitioner permanent partial disability benefits of $735.37/week for 28.875 weeks (23.75 weeks for the repetitive carpal tunnel injury, calculated at a 190-week value, plus 5.125 weeks for the tendon transfer, calculated at a 205-week value), because the injuries sustained caused the 15% loss of use of the left hand, as provided in Section 8(e)(9) of the Act. [As indicated in the attached decision, the Arbitrator makes a higher award for the left hand based on Dr. Labana's February 29, 2016 operative report, which documented a wrist tendon transfer.] Respondent shall also pay Petitioner

permanent partial disability benefits of $735.37/week for 30.4 weeks, because the injuries sustained caused the 20% loss of use of each thumb, 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.

Molly C Mason

Signature of Arbitrator

6/27/17
Date

CORRECTED DECISION ISSUED 7/19/17

JUL 19 2017

William Angell v. School District 170
15 WC 11431

Summary of Disputed Issues

Petitioner, a school custodian who has worked for Respondent for 23 years, claims bilateral carpal tunnel syndrome and bilateral CMC joint arthritis manifesting January 27, 2015. He underwent carpal tunnel releases in July and August 2015 and thumb surgeries in November 2015 and February 2016. He resumed full duty thereafter and was still working for Respondent as of the 2017 hearings.

Respondent does not dispute accident, causation or notice with respect to the bilateral carpal tunnel condition. Respondent paid for the bilateral carpal tunnel releases. RX 5. The disputed issues include accident, notice, causal connection, medical expenses, temporary total disability, credit and nature and extent. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified he has worked as a custodian for Respondent school district for 23 years. He is right-handed. He underwent bilateral rotator cuff repairs for work-related shoulder problems about 8 to 13 years ago. T. 2/17/17 at 14-15. He denied injuring either hand before his January 27, 2015 accident. T. 2/17/17 at 15.

Records in RX 10 reflect hand-related treatment dating back to December 15, 2009. On that date, Dr. Coats of Well Group Health Partners noted a complaint of bilateral thumb pain, worse on the right, "that started about a year ago." He described Petitioner as right-handed. He obtained bilateral thumb X-rays with CMC views. The radiologist interpreted the films as showing no acute fracture or dislocation of the wrist or thumbs, moderate symmetric degenerative changes of the first carpometacarpal joints bilaterally and mild left negative ulnar variance. RX 10, pp. 1-3. On January 18, 2010, S. Brown of Well Group Health Partners noted that Petitioner's right-sided symptoms were worse and that "_____ [illegible] on when wearing splints." RX 10, p. 4. When Dr. Coats examined Petitioner on January 18, 2010, he noted he was seeing Petitioner in follow-up "after Medrol DosePak and splinting for bilateral thumb CMC arthritis." He noted that Petitioner "works as a janitor" and was starting to use his right index and middle fingers to turn keys due to thumb pain. He also noted that Petitioner's left side was "becoming more symptomatic due to increased use." On re-examination, he noted tenderness to palpation at both thumb CMC joints with a positive CMC grind test. He injected the right and left thumb CMC joints and directed Petitioner to return in four to six weeks. RX 10, pp. 4-5. On March 1, 2010, Dr. Coats noted that Petitioner reported worsening right thumb pain but wanted to defer surgery because he had no sick time due to having "had his knees done." He indicated he planned to try to treat Petitioner via injections until Petitioner had built up his sick time again. He injected the right thumb CMC joint and recommended that Petitioner return in a couple of months. RX 10, p. 7. Petitioner next saw Dr. Coats on January 24, 2011, at which point he indicated the second injection had "lasted for quite some time" but he was again symptomatic. Petitioner also reported that his CMC splints had worn out. On re-examination, Dr. Coats again noted positive CMC grind testing at both thumb CMC joints. He injected both joints and recommended new CMC splints. RX 10, p. 11. Dr. Coats injected both CMC joints again on March 7, 2011 and recommended continued splint usage. He indicated Petitioner would be a candidate for CMC arthroplasty if the injections did not provide relief after four to six weeks. RX 10, pp. 12, 27-28. On January 30, 2012, Dr. Coats noted that Petitioner complained of typical 5/10 bilateral thumb pain that increased to 7-8/10 "after playing video games."

RX 10, p. 15. On re-examination, the doctor again noted positive CMC grind tenderness and tenderness to palpation. He re-injected both thumb CMC joints and directed Petitioner to return in six weeks for repeat X-rays. RX 10, p. 19. On March 12, 2012, Dr. Coats indicated that repeat X-rays showed "progression of the arthritis with still a small amount of joint space seen on plain films bilaterally." He noted that Petitioner reported relief secondary to the injections. He directed Petitioner to return when the injections wore off. He indicated Petitioner will "certainly at some time need CMC arthroplasty but when that is is yet to be determined." RX 10, p. 20. On January 14, 2013, Dr. Coats noted persistent thumb complaints and a new complaint of bilateral hand pain "which runs into the fingers and is worse at night." He indicated that Petitioner reported noticing some numbness and tingling in his hands during the last several years, while mopping at work, but "never really paid much attention to it until recently, when it started to get worse and started to involve other activities, other than mopping, while at work as well." After re-examining Petitioner, the doctor diagnosed bilateral carpal tunnel syndrome as well as bilateral thumb CMC arthritis. He injected both carpal tunnels and both thumb CMC joints. He prescribed a Medrol DosePak and directed Petitioner to return in four to six weeks. RX 10, p. 23. At the next visit, on February 11, 2013, Dr. Coats noted that Petitioner reported doing well for two weeks, following the last set of injections, but became symptomatic again "as soon as he started the occupational therapy." The doctor noted that Petitioner asked him "what work has done to his thumbs and his carpal tunnel." He attributed Petitioner's condition to both his janitorial work and his probable "natural proclivity to the thumb CMC arthritis." He viewed the janitorial work as "certainly an exacerbating factor in both diseases." He indicated Petitioner was using braces on an "as needed" basis. He recommended that Petitioner finish the last week of therapy and return to him as needed once he was ready to proceed with surgery. RX 10, p. 26. Dr. Coats saw Petitioner again on August 11, 2014. He noted that Petitioner complained of "paresthesias throughout the day" and that Petitioner described his hands as "better now that he's been off of work for a week of vacation." He indicated that Petitioner complained of only minimal nocturnal symptoms and denied CMC pain. He injected both carpal tunnels and directed Petitioner to return in four to six weeks. RX 10, pp. 34-36.

Petitioner testified he typically works 40 hours per week. He occasionally works overtime but it is not required. T. 2/17/17 at 15. His duties vary, depending on the time of year. During the school year, he regularly takes out garbage, buffs floors, opens the building and classroom doors and sets up/takes down the lunchroom area. During the summer, he strips and waxes the floors. In preparation, he must move various items of furniture, including tables and desks. A teacher's desk can weigh about 200 pounds. T. 2/17/17 at 16-17. A lunch table weighs 150 to 200 pounds. T. 2/17/17 at 17. He regularly carries 10-gallon buckets of water. A full bucket weighs 80 pounds. T. 2/17/17 at 18.

Petitioner testified he has never been written up or disciplined during his tenure at Respondent. He is evaluated every two years and always receives great reviews. T. 2/17/17 at 18.

Petitioner testified that, starting about six months before January 2015, he noticed tingling in the tips of his fingers in both hands. This tingling worsened over time and began to affect his hands. He continued working. As time went by, he began dropping items at work. T. 2/17/17 at 19-20.

Petitioner testified he initially sought treatment with Dr. Coats, who injected his thumbs and hands on several occasions. The injections "would help for a while" but his symptoms would return and worsen. Sometimes he had to hold keys between his index and middle fingers in order to unlock doors at the school because his thumbs hurt a lot. T. 2/17/17 at 21.

Petitioner testified that, on January 27, 2015, he tried to perform his regular duties but his bilateral hand and thumb symptoms had progressed to the point where he "just couldn't take it anymore." He reported his symptoms to his supervisor, Anthony Leli, and filled out an Employee First Report of Injury at the end of the day. He continued working thereafter. T. 2/17/17 at 23.

PX 3 is an "Ergo Insight WC Employee Injury Report" which bears Petitioner's signature and the date January 27, 2015. In this report, Petitioner listed a date of accident of January 27, 2015. He indicated the accident involved his "hands/wrists." In response to a question asking how the accident occurred, he wrote:

> "Ongoing problem with carpal tunnel. I was diagnosed about 1 ½ years ago by Dr. Coats. Pain and numbness have increased."

Petitioner responded "yes" to a question asking whether he had prior workers' compensation claims. He indicated he underwent "shoulder surgery x 2." PX 3.

Petitioner testified he underwent treatment with Dr. White "at the workman's comp office." He believes he saw Dr. White only once. The doctor examined both of his hands and told Petitioner he thought he had carpal tunnel. He referred Petitioner to Dr. Coats.

Records in PX 5 and RX 10 reflect Petitioner saw Dr. Ward, not Dr. White, at Working Well on January 27, 2015. The records set forth a date of injury of January 20, 2013. They describe Petitioner's chief complaint as follows:

> "States he has had bilateral carpal tunnel for 2 years, has been treated by Dr. Coats with injections of cortisone – last saw him 8/14, now having more pain so his workplace sent him to occ med."

The records describe "aggravating factors" as "bending wrists" and "alleviating factors" as "wearing wrist braces."

On wrist examination, Dr. Ward noted tenderness to palpation, 4/5 strength and positive Tinel's testing bilaterally. There is no indication the doctor examined Petitioner's thumbs.

The doctor diagnosed bilateral carpal tunnel syndrome. He recommended that Petitioner wear bilateral wrist braces, removing them at night, and "continue Celebrex per Dr. Coats." He also recommended that Petitioner see a hand surgeon. He noted Petitioner "prefers to continue seeing Dr. Coats." He released Petitioner to restricted duty, indicating Petitioner "must wear splint at work." PX 5, RX 10.

Petitioner testified he returned to Dr. Coats thereafter. The doctor administered another injection and scheduled bilateral thumb and hand surgeries.

On February 2, 2015, Dr. Coats noted an "at least 2 year history of bilateral hand pain, numbness and tingling," now worse on the right. On re-examination, he noted pain with CMC grind testing, decreased light touch sensation in the long and ring fingers of both hands and no atrophy. He recommended EMG testing and bilateral thumb X-rays. PX 6.

Petitioner testified that, on February 25, 2015, a woman came to his workplace, asked him some questions and told him to demonstrate the tasks he performs at work. The woman videotaped him while he repaired a vacuum cleaner, mounted a soap dispenser on a wall, buffed a floor for a short period, swept the lunchroom, lifted a table and put it back in place and took out garbage. The woman wanted to videotape him using a floor scrubber but he told her he could not do that because a scrubber can only be used while actually stripping a wet floor. If you use a scrubber on a dry floor, it tears up the wax. T. 2/17/17 at 26. He believes the woman obtained about 20 to 30 minutes of footage. He has watched the video. No one was with the woman.

Petitioner testified he underwent an examination by Dr. Vitello on March 16, 2015, at Respondent's request. He believes a member of the doctor's staff took his history. T. 2/17/17 at 28. The doctor tested the sensitivity and strength in both of his hands and asked him to show the area on his thumbs where Dr. Coats administered injections. The doctor then said, "okay, you are going to go for X-rays on your right hand." T. 2/17/17 at 29. He perceived the doctor as curt. T. 2/17/17 at 30.

In his report of March 24, 2015, Dr. Vitello, an orthopedic surgeon, indicated he reviewed various documents, including a Form 45, a job description, Dr. Coats' note of August 14, 2014 and the Working Well records. [The Arbitrator notes no Form 45 is in evidence.] He also indicated he viewed a job video dated February 25, 2015 which showed Petitioner tying garbage bags and throwing the bags into a dumpster, using a broom and dustpan to sweep up debris in a cafeteria, mopping the cafeteria floors, operating a large electronic floor buffer and using a manual screwdriver to remove brackets from a wall.

Dr. Vitello noted that Petitioner complained of numbness in the radial three digits of both hands and some pain in both thumbs. He indicated that Petitioner described his finger numbness as worsening in August 2014, when he was using the buffer while school was out of session. He also noted that Petitioner reported wearing splints and was wearing the splints at the time of the evaluation. He described Petitioner as a non-smoker with a "high body mass index" who had been performing the same job for 21 years.

On bilateral hand and wrist examination, Dr. Vitello noted positive median nerve compression testing, positive Tinel's and Phalen's, tenderness over the CMC joint of both thumbs, a positive grind maneuver, negative Finkelstein's and full active wrist flexion and extension. He saw no signs of intrinsic or thenar atrophy.

Dr. Vitello obtained bilateral hand X-rays. He interpreted the films as showing "Grade II-III CMC arthritis bilaterally."

Dr. Vitello assessed Petitioner as having bilateral hand numbness and tingling as well as bilateral thumb CMC arthritis. He indicated he did not have an EMG to confirm carpal tunnel syndrome.

Dr. Vitello responded as follows to a question asking whether Petitioner's bilateral carpal tunnel syndrome was related to his work duties:

> "Yes, given the nature and extent of his work. It is manual, repetitive, forceful and at times heavy. I would consider this consistent with development of carpal tunnel syndrome and medial nerve compression.

> He does not have the diagnosis of carpal tunnel syndrome at this point as we do not have an EMG to confirm this. However, these types of job activities and the types of work duties as witnessed in the job video and what was described in the narrative would be consistent with the potential development of carpal tunnel syndrome."

Dr. Vitello went on to identify Petitioner's high body mass index as a "contributing or co-morbid condition to his bilateral carpal tunnel syndrome." He described Petitioner's subjective complaints as consistent with carpal tunnel syndrome and mild to moderate CMC joint arthritis.

With respect to treatment options, Dr. Vitello recommended that Petitioner undergo a bilateral EMG prior to making a decision regarding bilateral carpal tunnel releases. He did not find Petitioner to be at maximum medical improvement, given the need for the EMG. He did not view Petitioner as requiring any additional care for his CMC arthritis, since he described his thumb symptoms as minor. He found Petitioner capable of continuing to perform full duty, so long as he used his splints. He found the splint usage to be related to the work injury. RX 1.

On April 7, 2015, Petitioner filed an Application for Adjustment of Claim, alleging bilateral carpal tunnel and thumb injuries of January 27, 2015 secondary to repetitive use of hand tools.

Petitioner underwent a bilateral upper extremity EMG on April 9, 2015. The examining neurologist, Dr. Rozenfeld, described the study as significant for bilateral carpal tunnel syndrome and a right ulnar neuropathy secondary to compression at the elbow. PX 6, pp. 20-23.

Petitioner returned to Dr. Coats on April 17, 2015. In his note of that date, the doctor indicated that Petitioner had undergone an IME and had brought the IME report to the appointment. He also indicated that Petitioner was now complaining of more pain in his thumbs than his wrists. PX 6, p. 11. He reviewed the EMG results. On re-examination, he noted positive Tinel's at both carpal tunnels and tenderness to palpation at both thumb CMC joints with positive CMC grind testing. He issued new braces, noting that Petitioner's "old braces are held together with duct tape." He recommended bilateral endoscopic carpal tunnel releases with thumb CMC arthroplasty, indicating he planned to operate on the left side first "because it is the more symptomatic at this time." PX 6.

Dr. Coats issued an undated report addressed "to whom it may concern," opining that Petitioner's bilateral carpal tunnel and CMC joint arthritis stemmed from the "work [he] has been doing repetitively over the years." He reiterated his surgical recommendation. PX 6.

On May 18, 2015, Dr. Vitello issued an addendum, after reviewing the EMG report and Dr. Coats' April 20, 2015 surgical recommendation. Dr. Vitello found a causal relationship between Petitioner's job and the conditions, i.e., bilateral carpal tunnel syndrome and right ulnar neuropathy, shown on the EMG. He opined that Petitioner's "job entails a combination of repetitive manual labor, forceful and, at times, heavy work, that could contribute to or exacerbate the development of bilateral carpal tunnel syndrome and right ulnar nerve compression." He described the need for bilateral carpal tunnel releases as "medically necessary and related to the January 27, 2015 injury." He did not recommend that Petitioner undergo CMC arthroplasty surgery, since he did not voice significant complaints of thumb pain. He described a CMC arthroplasty as a "much bigger operation" with a higher

risk of morbidity and a longer recovery period than a carpal tunnel release. He estimated a 6-week recovery period for a carpal tunnel release and a 3- to 4-month recovery period for a CMC arthroplasty. He found that Petitioner was not at maximum medical improvement with respect to his bilateral carpal tunnel syndrome. He found Petitioner capable of continuing full duty with use of bilateral wrist splints. He indicated Petitioner would need to be restricted to light to sedentary duty for four to six weeks following a carpal tunnel release. RX 2.

Petitioner testified that, after he saw Dr. Vitello, he received a letter indicating that bilateral carpal tunnel surgery was being authorized but that bilateral thumb surgery was being denied. T. 2/17/17 at 31. At that point, Dr. Coats had moved to Indiana and was no longer in his insurance plan so he consulted Dr. Labana at Premier Orthopaedic. Dr. Labana examined him and agreed with the need for bilateral hand and thumb surgery. T. 2/17/17 at 31-32. In his note of July 2, 2015, Dr. Labana opined that Petitioner's work "has also at least contributed to his first CMC arthritis" and that the proposed surgeries "should be covered under workers' compensation." PX 12. Dr. Labana performed left carpal tunnel surgery on July 24, 2015 and right carpal tunnel surgery on August 28, 2015. After the left-sided surgery, he was off work until August 16th. After the right-sided surgery, he resumed working on a light duty basis. The light duty lasted about a week. It consisted of inventory-related tasks at a warehouse. He then resumed full duty until November 14, 2015. On November 16, 2015, Dr. Labana operated on his right thumb at St. James. The operative report reflects the doctor pinned the base of the first metacarpal to the second metacarpal, using K wires and pins. It also reflects the doctor removed loose bodies from the right wrist joint. PX 12. Petitioner testified that, following this surgery, he performed occupational therapy about three times a week. PX 12. Around Thanksgiving 2015, he had a reaction to the dissolvable stitches and began experiencing a lot of pressure in his right hand. He met Dr. Labana at his office on Thanksgiving Day. The doctor unwrapped the thumb, squeezed it to release fluid and pulled a pin up about 1/8 of an inch. PX 12.

Petitioner continued attending occupational therapy thereafter, through February 18, 2016. PX 12.

Dr. Labana re-examined Petitioner on February 23, 2016, noting positive grind testing with pain in the left thumb. He recommended a left first CMC arthroplasty. PX 12.

Petitioner testified that Dr. Labana operated on his left thumb on February 29, 2016. The Arbitrator notes that the surgery Dr. Labana performed on this date differed from the right thumb surgery in that the doctor performed a wrist tendon transfer in addition to an arthroplasty. In his operative report, the doctor indicated he transferred a portion of the EPB tendon "to the base to help with stabilization." PX 12. Petitioner testified he again had a reaction to the stitches. Using his phone, he took a picture of his left thumb about a week after the surgery, in order to show the swelling. The photograph (PX 14) shows how his thumb looked at that point. T. 2/17/17 at 36, 45.

Petitioner testified he did not receive any workers' compensation benefits after November 14, 2015. He had to use his own insurance as well as his accumulated sick, personal and vacation days. He identified PX 17 as an "absentee report" he obtained from Respondent. T. 2/17/17 at 46-47. This report reflects Petitioner was absent from work 152 days between January 19, 2016 and June 30, 2016. He used 6 sick days (from January 19 – 26, 2016), 2 personal days (on January 27 and 28, 2016) and 14 vacation days (from January 29 – February 18, 2016). He took an FMLA leave from February 22, 2016 through June 30, 2016. Petitioner testified that once he used up all his allotted sick, personal and vacation days, he had to borrow funds from his Illinois Municipal Retirement Fund [IMRF] pension and

sign a repayment agreement. T. 2/17/17 at 37. If he prevails in his workers' compensation claim but fails to repay the amount he borrowed, he will receive less money when he retires. T. 2/17/17 at 38.

Petitioner testified that Blue Cross/Blue Shield paid his medical bills. T. 2/17/17 at 36.

Dr. Labana released Petitioner from care on June 27, 2016, noting improvement. He continued to keep Petitioner off work. He released Petitioner to return to work as of July 5, 2016. PX 12. Petitioner testified that school was out by this time. He began performing his usual summer duties, including moving furniture and scrubbing floors. He took Tylenol as needed for pain. He has not undergone any additional care or sustained any re-injuries. T. 2/17/17 at 38-39.

Petitioner testified he no longer has the same strength and dexterity in his hands and thumbs. He needs assistance to open a jar. The other day he was trying to fasten a pencil sharpener to the wall at work. He had difficulty maintaining a grip on the screw and dropped it a couple of times. T. 2/17/17 at 39-40. He does not have the same grip strength he had before the accident.

Under cross-examination, Petitioner testified he began working as a custodian for Respondent on October 25, 1993. T. 2/17/17 at 48. He denied working as a custodian/maintenance man at the Polish American Club for about six years before being hired by Respondent. T. 2/17/17 at 48. He acknowledged working in the building trades before his hire date. T. 2/17/17 at 48. The work he did before starting to work for Respondent included masonry, carpentry, labor tasks relating to pipefitting (but no actual pipefitting) and occasional painting and drywalling. T. 2/17/17 at 47-49.

Petitioner identified his signature on a two-page job application he completed before beginning to work for Respondent. One of the questions on the application asked whether he had experience as a custodian. He answered "yes," indicating he worked as a custodian at the Polish American Club. T. 2/17/17 at 50-51.

Petitioner acknowledged engaging in motorcycle riding, shooting guns at a range and playing video games when he was younger. He did not work on his motorcycle because he is "very unmechanical." He has not shot a gun at a range in a long time. He used to smoke. T. 2/17/17 at 52-53. He filed workers' compensation claims for his bilateral shoulder injuries. He settled those claims. T. 2/17/17 at 53.

Petitioner testified he does not recall seeing Dr. Coats on December 15, 2009 and complaining of bilateral thumb pain of about one year's duration. T. 2/17/17 at 54. He also does not recall whether the doctor obtained bilateral thumb X-rays on that date. T. 2/17/17 at 55. He cannot recall returning to Dr. Coats on January 18, 2010 or the doctor diagnosing bilateral thumb CMC arthritis on that date. T. 2/17/17 at 55. He does remember the doctor giving him injections but he cannot recall the exact dates. T. 2/17/17 at 56. If the records say the doctor injected both of his thumbs on January 18, 2010, he would agree. He does not recall the doctor injecting his right thumb and discussing bilateral thumb surgery with him on March 1, 2010. Nor does he remember telling the doctor he wanted to defer the surgery because he had just undergone knee surgery and had run out of sick time. T. 2/17/17 at 57. He has no reason to question the accuracy of the records. He just cannot recall the dates on which he saw the doctor. He recalls the doctor giving him splints but he cannot recall exactly when this occurred. T. 2/17/17 at 57-58. He does recall the doctor re-injecting his thumbs on March 7, 2011 and telling him to continue wearing the splints. T. 2/17/17 at 58. He also recalls the doctor telling him he would be a candidate for thumb surgery. T. 2/17/17 at 59. He remembers undergoing bilateral thumb X-rays on

March 7, 2011. T. 59. He cannot recall seeing Dr. Coats again on January 30, 2012 but, again, that is due to his uncertainty about the date. He guesses he recalls telling the doctor his thumbs had been bothering him for about two years. T. 2/17/17 at 59-60. He also remembers telling the doctor he aggravated his thumbs while playing video games. T. 2/17/17 at 60. The doctor administered more injections at that time. If the records show that, in approximately February 2013, the doctor told him he would eventually need bilateral thumb surgery, he has no reason to disagree. He also saw Dr. Coats for carpal tunnel before January 2015. The doctor injected both of his wrists before that time frame. T. 2/17/17 at 63.

Petitioner testified he has group health insurance with Blue Cross/Blue Shield through Respondent. Respondent contributes to his health insurance benefits. T. 2/17/17 at 64. Blue Cross/Blue Shield paid some of the expenses associated with his thumb surgeries. Workers' compensation covered his bilateral carpal tunnel surgery. T. 2/17/17 at 64. It was between approximately February 19, 2016 and July 4, 2016 that he received benefits from IMRF. He was told the payment of these benefits was "like a loan" and he would have to pay them back. T. 2/17/17 at 66. He received paychecks from Respondent between January 24 and February 19, 2016. He believes these paychecks represented his accumulated sick, personal and vacation days. T. 2/17/17 at 67. The paychecks were in the same amount as his regular salary. T. 2/17/17 at 68. He resumed receiving his regular salary, via paycheck, after he resumed working in July 2016. He is still receiving those paychecks. T. 2/17/17 at 68. He now earns more than he used to, due to a raise. He last saw Dr. Labana on June 27, 2016. T. 2/17/17 at 69. He takes Tylenol for his ongoing symptoms because "prescription medicine doesn't suit [him] well." T. 2/17/17 at 69. He has no upcoming doctor appointments regarding his hands or thumbs. T. 2/17/17 at 70. The swelling he developed in his left thumb postoperatively went away after Dr. Labana squeezed his thumb. T. 2/17/17 at 70. The work he performs during the summer is different from the work he performs during the school year. T. 2/17/17 at 70-71. The weights he provided on direct examination are estimates. He has never weighed the items he lifts at work. T. 2/17/17 at 71.

On redirect, Petitioner clarified he works four ten-hour days per week during the summer. T. 2/17/17 at 73-74. It is during the summer that he has to scrub and wax all the floors. T. 2/17/17 at 71-72. He did not have a specific accident involving his hands or thumbs. His symptoms "slowly built up over time and got worse and worse." T. 2/17/17 at 72. He knows Dr. Coats gave him injections and recommended surgeries. He just does not remember the dates. He last rode a motorcycle over 20 years ago. He used to belong to a gun club and would occasionally shoot guns at a range but this "got too expensive." He has not shot guns for a couple of years. He has not been to a range in three or four years. T. 2/17/17 at 73.

Respondent called two witnesses at the continued hearing of May 11, 2017. **Michelle Aldana** testified she has worked for Respondent for 3 years and 7 months. She is Respondent's payroll administrator. She handles the payroll for the ten schools within Respondent's district. She knows Petitioner in a professional capacity and administers his payroll as part of her job.

Aldana identified RX 7 as Petitioner's pay history for the period January 1, 2014 through January 31, 2015. This document was created in the regular course of Respondent's business.

Aldana identified RX 8 as Petitioner's pay history for the period January 27, 2015 through February 14, 2017.

Aldana identified RX 9 as a group of letters she received from IMRF [Illinois Municipal Retirement Fund] on various dates in 2016 concerning Petitioner's application for disability benefits. Upon receipt of each letter, she took the letter to the Respondent employee who handles disability claims. Respondent requires the letters to verify that Petitioner is off work and receiving disability benefits. Petitioner is not entitled to receive regular paychecks while receiving disability benefits. Copies of the letters are placed in Petitioner's personnel file and a separate IMRF file. Her supervisors, Anthony Leli and Loretta Perez, instructed her as to how to handle correspondence from IMRF.

Under cross-examination, Aldana testified the district office where she works is connected to an elementary school. She knows Petitioner by sight. The letters in IMRF are not signed and do not identify any contact person. They do, however, show a telephone number that can be dialed if the recipient wants more information. Petitioner is still working for Respondent. She does not deal with workers' compensation payments and does not know which Respondent employee handles such payments.

Beth Janicki Clark, IMRF's associate general counsel, testified pursuant to subpoena. IMRF is a pension fund established by statute to provide benefits to non-certified school district employees, among others. Employers are required to enroll qualified employees in IMRF, assuming those employees work at least 600 hours per year. Petitioner is enrolled in IMRF. IMRF provides temporary disability benefits to members who apply and qualify.

Clark identified RX 15 as a payment agreement between IMRF and Petitioner. The first box in this document reflects that Petitioner is entitled to $2,939.48 per month for temporary disability. The second box shows a "reduction date" of February 19, 2016. This is the date Petitioner qualified for temporary disability benefits. The third box shows a "reduction amount" of $2,929.48. This reduction is based on the offset provision in Article 7 of Chapter 40 of the Pension Code. A member's temporary disability benefits are offset by any Social Security disability or workers' compensation benefits he receives. There is a $10 difference between the amount Petitioner is qualified to receive and the "reduction amount." Petitioner is paid a token $10 per month so as to preserve his service for pension purposes. Petitioner signed the agreement on April 28, 2016.

Clark testified she is unable to state when the agreement was created. The middle section of RX 15 states, in bold print, that, in order for the member to receive checks, the agreement must be corrected if the member is awarded Social Security disability or workers' compensation benefits.

Clark testified that an employee such as Petitioner contributes 4.5% of each paycheck to IMRF. Under the agreement, Petitioner could, hypothetically, receive $20,000 if he had already paid in this amount to IMRF.

Clark testified that IMRF benefits are not in the nature of a loan. If a member who receives such benefits is awarded temporary total disability benefits, he must repay all of the IMRF benefits he has received other than the $10 payments. A member is not required to repay benefits if he is not awarded temporary total disability benefits.

Clark testified that RX 13 lists all of the IMRF disability payments Petitioner received between 2009 and April 4, 2017. [The parties agree the 2009 payments pre-date the claimed accident and have no bearing on this case.] In 2016, Petitioner received IMRF payments in these amounts: $1.72, $12.07,

$3,769.86, $2,818.08, $2,050.88, $1,440.35 and $2,630.25. On April 4, 2017, Petitioner received a payment in the amount of $13.79. [The 2016 and 2017 payments total $12,737.00.]

Under cross-examination, Clark testified that it is prudent for any employee who is receiving temporary total disability benefits to apply for IMRF disability benefits. This is because the receipt of temporary total disability benefits does not create service credit for pension purposes. She does not know whether Petitioner received temporary total disability benefits while receiving IMRF benefits. She agreed that the payments listed on RX 13 show only the issue dates and not the periods covered by each payment. PX 21, in contrast, shows the benefit periods. IMRF benefits are statutory in nature.

The payment disbursement documents in PX 21 reflect that the $1.72 payment covers the period February 1_ [second number is not legible] 2016 through February 23, 2016, that the $12.07 payment covers the period February 21, 2016 through March 31, 2016, that the $3,769.86 payment covers the period February 19, 2016 through March 31, 2016, that the $2,818.08 payment covers the period April 1, 2016 through April 30, 2016, that the $2,050.88 payment covers the period May 1, 2016 through May 22, 2016, that the $1,440.35 payment covers the period May 23, 2016 through June 6, 2016 and that the $2,630.25 payment covers the period June 7, 2016 through July 4, 2016. PX 21.

At the conclusion of Clark's testimony, the Arbitrator admitted RX 13 and RX 15 into evidence, with no objection from Petitioner. The Arbitrator also admitted PX 21 into evidence.

Although Petitioner originally disputed the receipt of $1,983.38 in temporary total disability benefits via a check dated September 15, 2015 (RX 14), his counsel stipulated to receipt of these benefits at the May 11, 2017 hearing. The Arbitrator admitted RX 14 into evidence, with no objection from Petitioner, and the parties amended the Request for Hearing form to reflect they stipulate to the $1,983.38 payment. The check reflects that the $1,983.38 represents temporary total disability benefits from July 24, 2015 through July 27, 2015 and August 28, 2015 through September 8, 2015.

Arbitrator's Credibility Assessment

In Respondent's video and at the hearing, Petitioner came across as a motivated individual who enjoys his job. His lengthy tenure with Respondent weighs in his favor, credibility-wise. Respondent's examiner, Dr. Vitello, did not note any symptom magnification.

Overall, the Arbitrator found Petitioner very credible.

Arbitrator's Conclusions of Law

Did Petitioner establish accident and causation with respect to his bilateral CMC joint arthritis condition?

The controversy in this case centers on Petitioner's bilateral thumb condition, not his bilateral carpal tunnel. RX 1-2. T. 2/17/17, p. 94.

The Arbitrator, having considered Petitioner's credible description of his duties, Respondent's job video, the medical records and Dr. Vitello's reports, finds that Petitioner established accident and causation insofar as his bilateral CMC joint arthritis condition is concerned. The Arbitrator further finds

that Petitioner established causation as to the need for the bilateral thumb surgeries Dr. Labana performed in 2015 and 2016.

With respect to accident, the Arbitrator views the selected manifestation date of January 27, 2015 as appropriate for both the thumb and carpal tunnel conditions. It was on January 27, 2015 that Petitioner, in his own words, "couldn't take it anymore" and filed a report. Respondent responded by sending Petitioner to an occupational clinic, where a physician recommended splint usage and a hand surgery consultation, noting Petitioner planned to return to Dr. Coats. Petitioner continued performing his regular duties thereafter (T. 2/17/17 at 23). and, in fact, demonstrated those duties to Respondent's investigator about four weeks later.

In Durand v. Industrial Commission, 224 Ill.2d 53 (2007), the Supreme Court emphasized that the Commission "should weigh many factors in deciding when a repetitive trauma injury manifests itself," given the varying scenarios, "to ensure a fair result for both the faithful employee and the employer's insurance carrier." The Court also held that a worker should not be penalized for continuing to work despite worsening symptoms. In the instant case, Petitioner continued working beyond the point where his symptoms became intolerable. Before he filed his Application, he facilitated Respondent's investigation by completing a report, visiting Working Well (a facility of Respondent's selection), submitting to an interview and videotaping and attending a Section 12 examination, with the examiner endorsing part of his claim. This is a scenario the Arbitrator has not previously encountered. The Arbitrator has weighed all of the competing factors in finding that Petitioner sustained repetitive trauma injuries manifesting on January 27, 2015.

The Arbitrator turns to the issue of causation. Based on his review of the job description and video, Dr. Vitello characterized Petitioner's tasks as "manual, repetitive, forceful and at times heavy." RX 1. PX 10. Respondent's unstated assertion, i.e., that these tasks stressed Petitioner's hands but not his thumbs, defies logic. The assertion is also not supported by any credible medical opinion. In his first report, Dr. Vitello responded affirmatively to the following, very specific question: "Is [Petitioner's] bilateral carpal tunnel syndrome causally related to his work duties?" He was not asked to address the issue of whether the thumb condition was also causally related. Instead, he was asked whether this condition warranted surgery. In both of his reports, he recommended against such surgery, based on the location of Petitioner's symptoms and the higher risk of post-operative complications. RX 1-2.

The Arbitrator relies on the foregoing, as well as the opinions voiced by Drs. Coats (PX 6) and Labana (PX 12), in finding causation as to Petitioner's bilateral thumb condition. That this condition might have been multi-factorial, with both work and recreational activities playing roles, does not preclude recovery. In Illinois, it has long been held that a claimant need only show that work was a factor in the development of his condition. He need not show that it was the sole factor or even a primary contributing cause. Nor is he obligated to eliminate all other possible causes. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003).

Did Petitioner provide Respondent with timely notice of his bilateral thumb condition of ill-being?

As with accident and causation, Respondent disputes notice only insofar as Petitioner's bilateral thumb condition is concerned. Specifically, Respondent asserts that Petitioner's written injury report of January 27, 2015 (PX 3) contains no mention of thumb problems. While this is true, the report clearly mentions encompassing body parts, i.e., the hands. It is not as if Petitioner saddled Respondent with the task of ferreting out injuries to more remote areas of the body. Moreover, Respondent had the

opportunity to fully investigate Petitioner's complaints and their origin within a month of January 27, 2015, via the individual who came to the school, interviewed Petitioner and obtained video of his job tasks on February 25, 2015. RX 3. This is discovery of the sort not contemplated by the Act. Finally, it is evident that Respondent had access to Dr. Coats' August 11, 2014 note, which discusses the thumbs as well as the carpal tunnel, before Dr. Vitello's examination of March 16, 2015, since the doctor references that note in his first report.

The purpose of the 45-day notice period is to allow the employer to fully investigate the nature and origin of an employee's injury. Seiber v. Industrial Commission, 82 Ill.2d 87 (1980). In the instant case, it cannot be said that Respondent's opportunity to investigate was hampered or delayed in any way.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims medical expenses from Premier Orthopaedic (Dr. Labana) and St. James Hospital. PX 12, 16. Respondent disputes liability for these expenses, based on its various defenses. The parties agree Respondent is entitled to Section 8(j) credit for a payment of $29,224.13 made toward the claimed hospital expenses. Arb Exh 1. T. 2/17/17 at 5.

The claimed expenses relate to treatment of the disputed bilateral thumb condition. The Arbitrator has previously found that Petitioner established causation as to this condition and the need for the thumb surgeries Dr. Labana performed. The Arbitrator further finds that these surgeries were reasonable and necessary. Respondent's examiner, Dr. Vitello, recommended against thumb surgery based on the symptoms Petitioner presented to him in March 2016 and the statistically high risk of post-surgical complications. While it appears Petitioner described his hand symptoms as his "primary issue" when he saw Dr. Vitello, he also mentioned bilateral thumb pain. RX 1. By the time he returned to Dr. Coats, on April 17, 2015, his thumb pain was worse than his wrist pain and the doctor recommended CMC arthroplasties as well as carpal tunnel releases. PX 6, pp. 11-12. Dr. Vitello did not acknowledge the reported worsening thumb symptoms in his addendum. RX 2. As for the risk of post-operative complications, Petitioner did in fact experience allergy-related swelling following both of his thumb surgeries but that swelling resolved, leaving him with overall improvement, as documented by Dr. Labana and the therapists who saw Petitioner postoperatively. Petitioner did not characterize the thumb surgeries as unhelpful.

The Arbitrator awards Petitioner the claimed medical expenses from Premier Orthopaedic (Dr. Labana) ($17,362.75, PX 12) and St. James Hospital ($14,798.43, right thumb surgery of November 16, 2015 and $17,637.53, left thumb surgery of February 29, 2016), subject to the fee schedule and with Respondent receiving 8(j) credit for the stipulated payment of $29,224.13. Arb Exh 1.

Is Petitioner entitled to temporary total disability benefits? Is Respondent entitled to credit?

At the hearing, Petitioner claimed two intervals of temporary total disability totaling 37 weeks. Arb Exh 1. Petitioner subsequently refined this claim. He now seeks benefits during the following three intervals: 7/24/15 through 7/27/15, 8/28/15 through 9/7/15 and 11/16/15 through 7/4/16. He agrees he received temporary total disability benefits during the first two intervals. [RX 14 establishes he actually received benefits from 7/24/15 through 7/27/15 and 8/28/15 through 9/8/15.] Respondent's payroll records, RX 8, to which Petitioner did not object (T. 5/11/17 at 52), reflect Petitioner also received his regular salary during those two intervals. With respect to the third claimed interval, the

payroll records establish Petitioner received his regular salary from November 29, 2015 through February 19, 2016 and from July 1, 2016 through July 4, 2016. RX 8.

The Arbitrator has previously found that Petitioner established accident, notice and causation with respect to his bilateral thumb CMC condition. Based on Dr. Labana's records (PX 12), the Arbitrator finds that Petitioner was temporarily totally disabled during the three intervals he claims: 7/24/15 through 7/27/15, 8/28/15 through 9/7/15 and 11/16/15 through 7/4/16. These intervals total 35 2/7 weeks. The Arbitrator finds Petitioner's temporary total disability rate to be $884.66 based on the stipulated average weekly wage of $1,326.99. The awarded benefits thus total $31,215.86. The Arbitrator further finds that Respondent is entitled to credit for the stipulated payment of $1,983.38 as well as the full salary paid during the intervals set forth in the preceding paragraph. The Arbitrator further finds that Respondent is entitled to Section 8(j) credit for the $12,737.00 in IMRF payments per RX 13 and Beth Clark's testimony.

What is the nature and extent of the injury?

Because the accident/manifestation occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in determining the nature and extent of Petitioner's injury. That section sets forth five factors to be considered in assessing permanency, with no single factor to be given more weight than any other. The Arbitrator views the first factor, i.e., any AMA Guides impairment rating, as irrelevant since neither party offered such a rating into evidence. The Arbitrator assigns significant weight to the second factor, Petitioner's occupation. That occupation, as described by Respondent's examiner, is "manual, repetitive, forceful and at times heavy." RX 1. The injuries involve Petitioner's thumbs and hands. Petitioner uses those body parts to perform most, if not all, of his assigned tasks. Petitioner credibly testified to reduced pinch and grip strength. The Arbitrator assigns some weight to the third factor, Petitioner's age at the time of manifestation. Petitioner was 56. He is an older worker but potentially has another decade to work with his injury. The Arbitrator views the fourth factor, future earning capacity, as not relevant. Petitioner resumed full duty in July 2016 and was still performing full duty as of the hearings. Petitioner did not claim any impairment of earnings secondary to his injuries. With respect to the fifth factor, "evidence of disability corroborated by the treating medical records," the Arbitrator notes the operative reports and occupational therapy notes. The operative reports reflect Dr. Labana inserted K wires and pins into Petitioner's thumbs. The second report also documents a wrist tendon transfer. The occupational therapy notes document complaints of persistent wrist achiness and reliance on splints and ice applications.

Having considered all of the foregoing, along with Petitioner's credible testimony concerning his ongoing hand and thumb complaints, and the fact Petitioner is right-handed, the Arbitrator awards permanency equivalent to 12.5% loss of use of the right hand (23.75 weeks), 15% loss of use of the left hand (23.75 weeks for the carpal tunnel injury, based on a 190-week value, plus 5.125 weeks for the tendon transfer, based on a 205-week value, per Section 8(e)(9)) and 20% loss of use of each thumb (a total of 30.4 weeks) under Section 8(e) of the Act. The Arbitrator awards a greater amount for the left hand than the right based on the wrist tendon transfer documented in Dr. Labana's operative report of February 29, 2016. The Arbitrator awards permanency at the weekly rate of $735.37 based on the stipulated average weekly wage and the applicable maximum.

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

Guillermina Gutierrez,
Petitioner,

vs.

Standard Parking,
Respondent.

18IWCC0355

NO: 13 WC 1421

DECISION AND OPINION ON REVIEW

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

In the first paragraph in the "FINDINGS" section of the Decision of the Arbitrator, the Commission deletes everything after the word "Act."

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

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 6 – 2018
o5/17/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0355

GUTIERREZ, GUILLERMINA
Employee/Petitioner

Case# **13WC001421**

STANDARD PARKING
Employer/Respondent

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

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

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

1702 GRAZIAN & VOLPE PC
VOLPE, RICHARD S
5722 S 63RD ST
CHICAGO, IL 60638

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

G. Gutierrez v. Standard Parking , 13 WC 01421

18IWCC0355

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

Guillermina Gutierrez
Employee/Petitioner

v.

Standard Parking
Employer/Respondent

Case # 13 WC 01421

An *Application for Adjustment 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 **May 9, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0355

FINDINGS

On 12/19/12, Respondent *was* operating under and subject to the provisions of the Act but as the case was later dismissed and not timely reinstated, the Arbitrator had no authority to entertain these proceedings or to render a decision.

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* causally related to the accident.

In the year preceding the injury, Petitioner earned $22,048.00; the average weekly wage was $424.00.

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

Claim for compensation denied. Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on December 19, 2012.

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

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

Signature of Arbitrator

June 21, 2017
Date

ICAbDec p. 2

JUN 26 2017

FINDINGS OF FACT

Petitioner was employed by Respondent as a cashier at the O'Hare Airport Parking Garage. She had been so employed for 8 years. She worked the 3rd shift, from 10:30pm to 7:00am. Her employer designates a parking area for its employees. It is accessed by a keycard and is not open to the public. After Petitioner parks in the designated lot, she walks across an area of the parking garage open to members of the public to Respondent's office in order to punch in and receive her assignment as to which station she will be working.

On December 19, 2012, Petitioner was walking from the designated parking area to the office, when she fell. Petitioner injured her left knee, left hip, left eye and eyebrow and sustained a fracture of the medial left orbital wall. She reported the accident to her supervisor and filled out an accident report. The report says that "Employee states that while walking from employee parking lot to the main office she tripped and fell..." (Px 8) She was taken to Resurrection Hospital emergency room by "security".

Petitioner testified that a hole of brick stone caused her to fall. She identified the "hole" as a dark spot depicted on pictures of the location of the fall that were admitted into evidence as Petitioner's Exhibits 6 and 7. It was Petitioner's testimony that the pictures truly and accurately portrayed the garage area where she fell. No testimony regarding the date and time of the photos was provided. The Arbitrator does not appreciate a defect or a trip hazard on Px 6 or PX 7.

At Resurrection, the history was that the patient works at O'Hare. She was walking from her car to work and she tripped and fell. Petitioner received stiches for a laceration and treatment for her left hip and knee. A fracture to the medial left orbital wall was seen. (Px 1)

Petitioner had follow up care with Dr. Foreman at Northside Medical Center (Px 2), J.W. Plastic Surgery (Px 3), University of Illinois (Px 4), and North Shore Orthopedics/Dr. Ronald Silver (Px 2). Torn menisci were seen on an MRI from MRI Lincoln Imaging. (Px 5)

The history documented by Dr. Foreman at the first office visit of January 16, 2013 was of left knee and hip pain, status post a work-related accident on 12/19/2012; on duty as a cashier, "fell to ground resulting in her injuries"; tripped and fell. (Px 2) The history charted by Dr. Silver on April 12, 2013 was that she was walking in a parking lot, tripped on (sic) a hole in pavement, twisted her left knee and fell on it. (Px 2) The history at J.W. was that the patient fell at work. (Px 3) The history at U of I was that the patient fell and hit her face. (Px 4)

Petitioner lost no time from work for treatment or for her injuries. Dr. Silver recommended surgery. Petitioner declined the offer. Petitioner has weakness in her left leg, it feels like it will give out. She has pain. The facial laceration healed, leaving a scar over her left eye, which is visible. The left orbital fracture healed. Petitioner feels that her eye is droopy.

Respondent presented the testimony of Emilio Gervasio. He is employed by Respondent as the Assistant General Manager at the O'Hare facility. He had this position in December of 2012. It is about ¼ of a city block from the parking lot to the office. You walk through the parking garage that is open to the public. Employees are not required to take any specific route in getting from the employee lot to the office. The route that Petitioner took is not the most direct route. The public walks through the area where Petitioner fell. Gervasio

thought that the gray mark depicted on Px 6 and Px 7 was a stain or salt residue from cars. He did not think that it was a trip hazard. Respondent has a management contract for the garage with the City of Chicago, Department of Aviation. Respondent inspects for defects and advises the City. Respondent hires contractors to make repairs, with the City's permission.

CONCLUSIONS OF LAW

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of her claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between her employment and her injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989) Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

WITH RESPECT TO ISSUE (O) JURISDICTION/APPROPRIATENESS OF REINSTATEMENT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent disagrees with the Arbitrator's reinstatement of this case on December 13, 2016 and raises this issue in order to preserve it for further appeal and to allow for judicial economy in the event that the Arbitrator now finds that the case should not have been reinstated. Of course, if the reinstatement was not correct, the remaining issues at trial are rendered moot.

This case was dismissed for want of prosecution by the Arbitrator on April 11, 2016. The Parties never received a Notice of Case Dismissal from the Commission. Petitioner filed a Petition to Reinstate on November 3, 2016. Respondent filed a reply on November 28, 2016. A hearing took place on December 13, 2016 and the Arbitrator, after considering the Petition, the Reply and the arguments of counsel, along with the obligations imposed by Rule 9020.90, granted the Petition to Reinstate.

The Arbitrator stands by that action and states his belief that the reinstatement was appropriate. Respondent can dispute this ruling on Review if it so chooses.

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner failed to prove that her accidental injuries sustained on December 19, 2012 arose out of and in the course of her employment by Respondent.

Petitioner's fall arguably occurred in the course of her employment, as she was walking from the employee parking lot to Respondent's office to punch in and be assigned to a pay booth to work. This action is certainly incidental to her employment as a parking lot cashier for Respondent at O'Hare airport.

The Arbitrator finds that the fall did not arise out of her employment by Respondent. First, the Arbitrator is not persuaded that there was a defect that caused the fall. Petitioner did give a consistent history of tripping and falling, but the cause of the trip (a hole?) was not described until the visit with Dr. Silver in April of 2013, some 4 months after the accident. Petitioner's Exhibits 6 and 7 do not show a hole or a defect in the floor. The

accident report and the histories to the emergency room and 3 physicians other than Dr. Silver do not mention a hole or any trip hazard. No defect makes the fall idiopathic, which does not support a finding of arising out of. Caterpillar v. Industrial Commission, 129 Ill. 2d 52 (1989)

Application of the theories of a quantitative or qualitative relationship between the accident and Petitioner's employment likewise fails to support a finding of arising out of. Petitioner was injured in an area of the garage open to and used by members of the public at large. The route that Petitioner took from the employee lot to the office was Petitioner's choice and there were other options available. The risk of injury appears to be neutral- the same as all members of the public that use the garage. Nothing about Petitioner's job increased her risk of injury (e.g.: she was not carrying anything associated with her work that contributed to the fall). There was no evidence of how many times per day Petitioner traveled between the lot and the office and no evidence that such travel was related to her work. Even if the Arbitrator found that there was a defect that caused Petitioner to trip and fall, the requisite nexis between Petitioner's employment and the fall has not been shown.

The accidental injuries did not arise out of Petitioner's employment by Respondent. Accordingly, the claim for compensation is denied. Vill v. Industrial Commission, 351 Ill.App. 3d 798 (2004)

WITH RESPECT TO ISSUES (F), IS 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 AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, AND (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

As the Arbitrator has found that Petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment by Respondent on the claimed accident date, the Arbitrator needs not decide these issues.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin McEvers,

Petitioner,

18IWCC0356

vs.

NO: 10 WC 45165

Craig Roberts & Son Trucking,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner, a 48-year-old truck driver, sustained accidental injuries to his right shoulder on May 25, 2010 when he slipped exiting a trailer and caught himself with his right arm. Petitioner underwent two right rotator cuff repairs and participated in a functional capacity evaluation. It is undisputed that because of his injuries Petitioner has permanent work restrictions that prevent him from returning to his usual and customary employment. Petitioner participated in vocational rehabilitation and job placement assistance provided by Respondent which was ultimately unsuccessful. The Arbitrator found that Petitioner is permanently and totally disabled from all employment on an "odd-lot" basis, there being no stable labor market available for Petitioner because of his age, training, education, experience, and condition. On review, we modify the Decision of the Arbitrator on the issue of the nature and extent of the injury. We find that Petitioner is permanently partially disabled to the extent of 55% of the person-as-a-whole as provided in Section 8(d)2 of the Act. We also modify the Arbitrator's award of mileage reimbursement.

After considering all the evidence, we find that Petitioner failed to prove he is permanently and totally disabled on an odd-lot basis. We find that Petitioner has a high school diploma and a long work history, including five years of owning his own trucking company. Petitioner is physically capable of sedentary, light duty, and medium-duty work and there is no evidence that Petitioner's appearance and presentation functions as a barrier to his employment in his local area. We find that Petitioner was not fully compliant with vocational rehabilitation or diligent in his job search and failed to put forth a good faith effort. We do not find the unsuccessful outcome of Petitioner's vocational rehabilitation to be an accurate indicator of his employability. Petitioner has the burden of proving by a preponderance of the evidence that he is so handicapped that he will not be employed regularly in the labor market. For the foregoing reasons, we find that Petitioner failed to meet his burden. An award of permanent partial disability benefits is appropriate where the injuries partially incapacitate an employee from pursuing the duties of their usual and customary line of employment. We find that Petitioner is entitled to permanent partial disability benefits to the extent of 55% loss of use of the person-as-a-whole pursuant to Section 8(d)2 of the Act.

Finally, we modify the Arbitrator's award of mileage reimbursement and vacate the award of mileage reimbursement for primary care visits. Petitioner treated with Dr. Richards and associated primary care medical staff at Springfield Clinic for medication and management of multiple medical conditions. We find that Petitioner was not required to travel outside of his local area to obtain the services rendered for primary care and we vacate the Arbitrator's award of mileage reimbursement. We agree with the Arbitrator's finding that Petitioner is entitled to mileage reimbursement for services provided by specialists Dr. Pineda and Dr. Wolters of Springfield Clinic specifically related to the work injury of May 28, 2010, mileage reimbursement for the two-day FCE at Memorial Industrial Rehab, and mileage reimbursement for work hardening at Midwest Rehab in Springfield. However, the Arbitrator utilized the 2017 IRS reimbursement rate for all reimbursable travel, although services were provided across a span of several years. Therefore, we modify the Arbitrator's Decision to order that mileage reimbursements shall be calculated according to the IRS standard mileage rate for the year in which services were rendered.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner combined TTD and maintenance benefits of $472.54 per week from May 26, 2010 through July 28, 2013. Respondent is entitled to credit against the amount owed in the amount of $70,139.92.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $472.54 per week for a period of 275 weeks, as provided in §8(d)2 of the Act, because the injuries sustained caused the loss of use of 55% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay medical expenses for reasonable and necessary treatment related to the work injury of May 28, 2010 under §8(a) and 8.2 of the Act and according to the applicable fee schedule. Respondent shall be given a credit for any medical benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION Respondent shall pay to

18IWCC0356

Petitioner mileage reimbursement for expenses incurred in obtaining reasonable and necessary medical treatment provided by specialists Dr. Pineda and Dr. Wolters of Springfield Clinic related to the work injury of May 28, 2010, the two-day FCE at Memorial Industrial Rehab in Springfield, and work hardening visits at Midwest Rehab in Springfield. Mileage reimbursements shall be calculated according to the IRS standard mileage rate for the year in which services were rendered.

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 6 – 2018
DLS/plv
o-5/3/18
46

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0356

McEVERS, KEVIN
Employee/Petitioner

Case# **10WC045165**

CRAIG ROBERTS & SON TRUCKING
Employer/Respondent

On 10/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% 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:

4599 SHUCHAT COOK & WERNER
CLARE R BEHRLE
1221 LOCUST ST SUITE 250
ST LOUIS, MO 63103

2904 HENNESSY & ROACH PC
EMILIE MILLER
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

18IWCC0356

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

Kevin McEvers
Employee/Petitioner

v.

Craig Roberts & Son Trucking
Employer/Respondent

Case # 10 WC 45165

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 **Quincy, IL**, on **September 7, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/25/2010**, 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 $**36,858.12**; the average weekly wage was $**708.81**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $ for TTD, $ for TPD, $**70,139.92** for maintenance, and TTD paid from 5/26/2010 – 7/28/2013 $ for other benefits, for a total credit of $

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

ORDER

Petitioner is entitled to combined TTD and maintenance benefits from 5/26/2010 through 7/28/2013. Respondent is entitled to credit against the amount owed in the amount of $70,139.92.

Respondent shall pay Petitioner permanent and total disability benefits of $472.54/week for life, commencing 7/29/2013, as provided by 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 reasonable and necessary medical services as set forth in the Conclusions of Law.

Respondent shall be given a credit for any medical benefits paid.

Respondent shall pay mileage reimbursement in the amount of $8220.54 for expense in obtaining medical treatment.

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

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

10/10/2017
Date

ICArbDec p. 2

OCT 19 2017

18IWCC0356

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Testimony at Arbitration

Before his injury, Kevin McEvers (Petitioner) had been working for Craig Roberts & Son Trucking (Respondent) for approximately three years. Respondent is a livestock hauler and Petitioner hauled pigs for the company driving from state to state. The job typically required him to be away from home during the week, leaving on Sunday and returning on Saturday. The job required heavy physical work. Petitioner would load and unload the pigs on the truck. It would require a lot of climbing, bending and stooping. If a hog died on the truck he would have to pull weights from 250 to 300 lbs to get it off the truck. On May 25, 2010, Petitioner and Craig Roberts were at the yard in White Hall working on a sprinkler system on a truck. Petitioner had been working on the top floor of the trailer and while climbing down to the bottom floor slipped and tried to catch himself with his right arm. Petitioner began to feel pain in his right shoulder radiating to his neck and he couldn't lift his arm above his shoulder.

He sought medical treatment that day at Memorial Hospital Emergency Room in Springfield, IL. He was x-rayed, given medication, and released. His complaints continued so he returned to the emergency room a day or two later and was referred to Dr. Pineda at Springfield Memorial. Dr. Pineda treated the Petitioner and after a point in time referred him to Dr. Wolters. After MRI testing Petitioner was diagnosed with a rotator cuff tear and Dr. Wolters performed a right rotator cuff repair on September 20, 2010. His operative report indicated there was a full thickness tear of the supraspinatus tendon along with extensive bursitis. (PX 10)

Following surgery Petitioner continued to have problems both with pain and function. After more testing and therapy Dr. Wolters performed a second rotator cuff repair surgery on September 26, 2011. Operative findings included significant biceps tendinopathy, extensive bursitis and a small tear in the area of the biceps tendon near the rotator cuff. (PX 9) Following surgery Petitioner had both physical therapy and work hardening. He underwent a Functional Capacity Evaluation at Memorial Rehab on January 10, 2013 and he was sent to Dr. Watson by the workers' compensation carrier for an IME.

The FCE report indicates that the Petitioner gave a maximal effort. He had shoulder and lower back discomfort while performing the test. It was determined that he was capable of performing Light to Medium work. (PX 5)

Dr. Wolters referred Petitioner to Midwest Rehab in Springfield, Illinois for work hardening and physical therapy for his shoulder and neck complaints. From February 9, 2011 through March 24, 2011 Petitioner attended the facility 27 times. Dr. Wolters referred him for work hardening involving his shoulder and Dr. Pineda referred him to therapy for his neck complaints. (Pet. Ex. 8). Petitioner's home address is 328 King Street, White Hall, Illinois 62092. He attended therapy at 1301 S. Koke Mill Road, Springfield, Illinois 62711. The shortest route through Google Maps is 107.8 miles roundtrip. Petitioner traveled 2,910.6 miles to attend therapy in Springfield.

On February 15, 2011, Dr. Pineda examined Petitioner in reference to neck complaints. Dr. Pineda thought he was having a mechanical problem and ordered a rehab program. On 3/23/2011 Dr. Pineda felt that overall he was doing better since he had undergone his therapy and he would see him back on a P.R.N. basis. He said Petitioner could do activity as tolerated.

Dr. Michael Watson evaluated Petitioner on behalf of the Respondent in June or July of 2012 after Petitioner had undergone his two shoulder surgeries. Dr. Watson examined Petitioner after the two shoulder surgeries performed by Dr. Wolters. At the time he saw him Petitioner was taking Vicodin for pain and using approximately six tablets per day. Subjectively he complained of pain in the right shoulder with popping and he described severe weakness.

On physical examination of the right shoulder Dr. Watson found active elevation limited to 110 degrees. An active abduction limited to 100 degrees. Strength was 4/5 and he found tenderness in the lateral subacromial space. He also found a positive drop-arm sign. Dr. Watson diagnosed recurrent right rotator cuff tear. He thought the condition was caused by the work injury and that all of the treatment to date had been reasonable and necessary and causally related to the work injury. He thought Petitioner was at maximum medical improvement and as he got temporary relief from cortisone injections he thought it would be reasonable for Petitioner to have occasional injections for pain control over the next year. Dr. Watson thought Petitioner was employable but that he could not work without restrictions. He believed his restrictions would include no lifting greater than 30 pounds and no overhead work with his right arm. He thought those restrictions were permanent. Dr. Watson thought there would be permanent partial disability and that all of that disability was causally related to the work injury. (Pet. Ex. 13).

Dr. Wolters found Petitioner to be at MMI on January 25, 2013 and placed permanent restrictions on him. In reference to the Petitioner's right arm, the doctor thought he should only do occasional lifting of 30 pounds, frequent lifting of 15 pounds, and no continual lifting over 10 pounds. Following his release Petitioner continued to see Dr. Wolters for injections, each one only helping his pain complaints for a day or two.

Since his release from Dr. Wolters, Petitioner treats with a family physician, Dr. Jennifer Richards, in Springfield, Illinois. She treats him for multiple conditions but in reference to his work injury she prescribes medications such as Lyrica, Soma, Xanax and a narcotic pain pill. He takes the narcotic pill on a daily basis, two tablets in the morning, two tablets at noon and two tablets around 5:00 p.m. Because he is prescribed a narcotic he has to visit, in person, with the doctor every three months to go over the drug management parameters. Additionally he has to travel to Springfield every month just to pick up his prescription. The last treatment note placed into evidence was dated July 6, 2015. At that time, Dr. Richards noted pain complaints to the right shoulder, low back and knees. Her note also contains the admonitions that the Petitioner not drive or operate heavy machinery while under the influence of the narcotic medicine as well as indicating the need to be seen every three months in the doctor's office to monitor the medications. (PX 12)

Petitioner testified that if he doesn't take the medication, "it's rough" and he has more pain. He thinks the medication affects his memory and slows his thinking. He has been cautioned by the doctors' about driving while on the narcotic medication. Petitioner has a hard time sleeping when he is on the medication and will feel dizzy or "out of balance."

Petitioner has not had any prior injury involving his right shoulder. In the 1980's he injured his neck in a motorcycle accident and had a neck fusion surgery. He currently treats for high blood pressure and has had three heart attacks. His first heart attack occurred when he was thirty-four years old. He had heart surgery to have a stent placed.

Petitioner could not return to work at Respondent and since his injury has not worked for anyone else. After his injury he received temporary total disability benefits. Once Dr. Wolters placed permanent restrictions on him he started receiving maintenance benefits. Those benefits stopped on July 28, 2013.

Petitioner graduated from high school in 1980. He has had no other schooling except for a one week course in how to work on brakes. He has no other training other

than training on the job. Petitioner does not read for pleasure and says he can sit and read a book and does not comprehend a lot. With the help of a calculator he can do "general math" - adding and subtracting. He does not know how to figure ratios or proportion or profit or loss. When asked if he has ever done math in any of his past jobs he notes he has figured freight work rates for his truck. Petitioner can write but he has never had to write reports nor has he ever had to use a computer in any of his past jobs. When he was in high school pumping gas he used a pull handle cash register.

Petitioner characterized all of his past work experience as labor work involving heavy physical work. Petitioner testified he has never worked in a customer service type job. He has never worked as a salesman or in the fast food industry. He has never worked a job where he has had to deal with the public. Petitioner's past work experience includes working at a filling station in high school pumping gas, changing oil and tires. He worked at a lawnmower repair shop and worked for a lumbar company driving a flatbed truck. He has changed tires on tractors and other agricultural equipment. He has driven trucks delivering cheese and fertilizer. From 1996 through 2000 he had his own trucking business. He drove for "Crop Mate", a retail fertilizer outlet, delivering fertilizer to Crop Mate's customers. When Petitioner had this business he did not have to find his own customers as his client was Crop Mate. He did not have to deal with the customers he delivered the fertilizer to. He had two other drivers that he would tell where they needed to deliver their loads. He did some incidental driving for some of the farmers in the area that he had worked for in the past. Petitioner's wife handled the business side of thing and kept the paperwork. A CPA company did the taxes. This business ended in 2000 when the fertilizer plants closed. Petitioner then worked as a farm hand and worked for a construction company operating heavy equipment. After that he worked for Craig Roberts Trucking hauling pigs.

When asked if he ever handled big sums of money Petitioner said he did – he'd get a check and deposit it in the bank. Petitioner testified that before his injury he never had to look for a job. He lives in a small community where everyone knows you and employers came to him or he got work through word of mouth. He never had to use a resume or had to "hit the pavement" to find work. Petitioner testified he does not consider himself to be an organized person nor does he have a good filing system.

After Dr. Wolters placed permanent restrictions on him Petitioner looked for work as he had looked in the past. He went to the people he knew to see if they were hiring. He was looking for anything he could do which he says was very little. He asked at places that provided farmhand, fertilizer or concrete construction work and admitted that he

would not be able to do those sorts of jobs with his restrictions but he also didn't know what else he could do.

In March of 2013 the workers' compensation carrier started providing vocational services and he worked with Ms. Kimberly Gee of S&H Management. Petitioner owned a computer when vocational services started but it was one his daughter used for school. His daughter showed him how to get on the internet and he used it to search for auctions. He had never used a computer to write letters or make reports or spreadsheets. He was not familiar with programs like Microsoft Word or Excel. He did not know that there were websites on which you could apply for jobs. He had never used email nor had he ever had an email address.

Ms. Gee helped him prepare a resume and told him how to interview. She instructed him in how to present himself and signed him up for free computer programs like Computer Basics, Internet Basics, Email Basics, Microsoft Word and Microsoft Excel. Petitioner testified that he had difficulty completing the classes. He said the classes were over his head, overwhelming, and he just couldn't grasp them. He would have difficulty logging in on his computer and there were times that he would have to take classes over because he hadn't logged in correctly. He passed classes some with 100% score, but said he was able to get that score because after taking the test the first time they give you the answers and you just took the test again. Even after taking the classes Petitioner never felt proficient in the programs and still does know how to use them. He would have to continually go to Ms. Gee for help with his computer. He would have problems using and logging into his e-mail. To date, he still does not use email.

Petitioner met with Ms. Gee on a regular basis traveling to Jerseyville, Illinois. When together she would show him how to log on to the computer and they would apply for jobs together on websites like Monster or CareerBuilder. Petitioner testified he had a hard time applying for jobs online when he was alone. Petitioner did not have internet access in his home and would use his neighbor's with his permission. His access, however, was limited based upon when his neighbor had his connection on.

At their meetings Ms. Gee would fill out applications for him and they would submit then together online. She also applied for jobs for him when they were not together. There were also occasions Petitioner would ask her to submit applications on his behalf because of his difficulty in using his computer. Petitioner testified he also made in person contacts with potential employers and made follow up calls. He had an interview in St. Louis for a job selling insurance. He did not receive an offer. Petitioner does not think he could sell insurance. He recalled interviewing at a hospital for

dishwashing work but testified he wouldn't have been able to do that work because of the weights he would have to lift. He wasn't offered that job either. He pursued a forklift job at SIUE Edwardsville until he was advised he would have to break down pallets and it was beyond his restrictions. Ms. Gee provided job leads for food related jobs, cashier position, customer service jobs, selling insurance or other sales jobs. Petitioner does not think he would be a good salesman. He was not offered a job from any potential employer.

Petitioner lives in a rural area surrounded by farms. White Hall has a population of about 3200 people. The closest bigger towns are Jacksonville and Jerseyville each about twenty-five miles away. Petitioner testified that he found it hard to find suitable jobs within his restrictions and he would run out of places to apply to. Some of the job leads he tried to develop were those of working as a bartender.

Petitioner agreed that he did not always return phone calls to Ms.Gee and and he did not always follow up with potential employers within the timeframe she wanted. He said she kept "feeding me all this stuff" and he couldn't take it in. Everything was coming too fast. He agreed he was criticized for not checking his emails but he said he never did grasp how to use his computer. Petitioner said he found the whole vocational process hard to do, depressing and overwhelming. He was still being bothered by pain for which he had to take the pain medication and just could not do the computer work. Petitioner felt that he was doing the best job he could with what he was being asked to do.

Petitioner's maintenance benefits stopped at the end of July of 2013 because the workers' compensation carrier did not think he was cooperating with the vocational services. At the same time he was advised that Ms. Gee's vocational services were being terminated. In spite of that Ms. Gee continued to leave messages for him throughout August which he did not respond to because he had been told the services had ended. He found this confusing and his attorney contacted the workers' compensation adjuster to tell her that Ms. Gee was still contacting him. After that the messages stopped.

Prior to his work injury at Respondent Petitioner did not have any problems or injuries involving his right shoulder. He was able to do all of his work activities and outside activities without problems. Prior to this injury his neck was not giving him any difficulties. He has not had any subsequent injuries involving his right shoulder or neck.

Petitioner still complains of ongoing problems involving his shoulder. He has pain on a daily and nightly constant basis. He is never without it. Increased activities

increase the pain. He characterizes his daily pain level as a 6 on a 10 point scale. He avoids lifting with his right arm trying to not lift greater than ten pounds. When he lifts more his pain radiates up through his shoulder and neck. He has trouble pushing or pulling. He can't reach over his head. He cleans his house and does the laundry. He mows his lawn which takes him all day because of the breaks he needs to take. If he drives using his right arm on the steering wheel it starts hurting. He can't sleep laying on his right arm. Extremes of heat and cold bother him. To alleviate his pain he will lie down and, once or twice a week, will use an ice pack. He no longer hunts, fishes or rides a motorcycle.

When Petitioner uses his right arm he gets a pain into his neck. He does note some neck complaints when he is not using his arm but it is not as extreme as his shoulder. Petitioner has leg and back complaints that began after his first surgery. He thinks someone dropped him off the table but no one has told him that. He has pain but he feels it does not limit him.

Petitioner started receiving social security disability in May of 2013. It is his only income. He received it for physical problems and payments dated back to his work injury. Petitioner testified that he was planning to work into his 60's before this injury occurred.

When Petitioner was receiving vocational assistance with Ms. Gee she asked to meet with him on a regular basis in Jerseyville, Illinois an approximate fifty mile round trip. He also made in person contacts with potential employers traveling to Jerseyville, Jacksonville, Winchester, East Harden and Eldrid, also approximately 50 miles roundtrip or a little less. He traveled to St. Louis for his sales interview.

Petitioner had to travel to Jerseyville for physical therapy as it was the closest location to his area. He traveled to Springfield for treatment both to the Springfield Clinic and Memorial Medical Center which is approximately 120 miles round trip. He was referred to these facilities from the emergency room and testified that there are no comparable specialists in his area.

Petitioner has to go in person to Dr. Richards in Springfield to pick up his prescription on a monthly basis. He also visits her three times a year. This has been the case since his release from Dr.Wolters. Petitioner testified it was a hardship for him at times to pay for gas to get to these appointments and is requesting mileage reimbursement.

Petitioner testified that he reviewed the exhibits entered into evidence and the records appear to be those showing treatment he received after this injury. He does not know if the office medical bills have been paid by workers' compensation and if not he is asking the arbitrator to reimburse those.

On cross examination Petitioner was asked if he told Ms. Gee that he was not interested in getting a job since he had gotten social security disability benefits. Petitioner admits saying that but that it was taken out of context. He did talk to her about it because he wanted to know how offsets would affect him. He testified if he had found a job he felt he could do he would have worked it. Other comments were reported in the vocational reports that Petitioner says were taken out of context such as not wanting to apply to McDonalds because he liked their sandwiches too much and not wanting to work because he had too much to do around the house. Petitioner testified that he jokes around a lot and such comment were not meant to be taken seriously.

He also testified that at the beginning of the voc process, expectations were set out for him and he was having difficulty meeting that requirement. At the end of the process the workers' compensation adjuster increased his requirements on employer contacts which made it even harder.

Ms. Karen Kane is a vocational consultant with Comp Alliance Managed Care and testified on behalf of Respondent. (Res. Ex. 4) Ms. Kane did an updated vocational survey and labor market survey in early 2006. She created a report dated April 26, 2016. To reach her conclusions she reviewed Ms. Gee's reports. She never met or spoke to Petitioner or his attorney. She does not recall speaking to Ms. Gee. (Res. Ex. 4 page 10).

Ms Kane testified that Petitioner was required to do five in person contacts per week and five to 10 telephonic contacts as well as five to 10 on-line employer contacts as needed. (Res. Ex. 4 page 14-15; *See also* Res. Ex. 5 & 6). Ms. Kane testified that Petitioner appeared to have "walked away from the services." She noted that Ms. Gee tried to contact him from August 2, 2013 through August 22, 2013 and did not receive any response. (Res. Ex. 4 page 16-17). Ms. Kane felt Petitioner was employable in the open labor market. She thought he could find an entry level job paying entry level at $8.25 to a job paying roughly $17.00 an hour. She thought the positives in his situation was a consistent past work history and that he had updated his computer skills with classes. Additionally she thought that where he lived was an asset because he had the ability to go to larger areas for employment. (Res. Ex. 4 page 29-30). Ms. Kane thought that Petitioner would have developed skills when he owned his own business as he would have to deal with customers, his drivers and the bank. (Res. Ex. 4 page 39).

Ms. Kane agreed permanent restrictions took Petitioner out of his prior job but not necessarily out of truck driving for no-touch freight. She acknowledged that the narcotic medications he took may take him out of that job although she indicated that different states seem to have relaxed that requirement. (Res. Ex. 4 page 41). Ms. Kane thought that the WRAT testing Mr. Dolan did was not reflective of Petitioner's abilities, suggesting he did not put forth a full effort. She did not agree that he had difficulty using technology and she questioned his motivation. She thought that his past shop classes in high school would have allowed him to apply the principles of math that was described in Ms. Gee's report. She did not believe Petitioner had performed a good faith job search. (Res. Ex. 4 page 41, 72, 78, and 81).

The jobs identified on the labor market survey that Ms. Kane prepared principally included customer service representative positions such as at Title Max, Tower Loans or other loan companies. It also identified customer service jobs such as being a guest service representative at a hotel. (Res. Ex. 4 page 87-89).

A review of Petitioner's high school transcript shows he graduated from high school in 1980. He made a few Bs, many Cs, some Ds, and failed a few classes. He had one A on his transcript, which was for General Shop in Ninth Grade. (He took 43 semester-length classes. He had 1 A, 10 Bs, 21 Cs, 7 Ds, and 4 Fs) He failed a semester of English in Ninth Grade and a semester in Tenth Grade. He made a B his first semester of English in Ninth Grade and a D his second semester of English in Tenth Grade. His remaining English grades were all Cs, including when he retook the classes he failed.His only math class in high school was in Ninth Grade, and he scored a C and a D. He had accounting in Eleventh Grade, and scored a C and a D.Mr. McEvers failed Personal Typing, and he made a D in Recordkeeping. He also failed his Architecture Drafting class. He did not retake any of these classes. (Res.Ex. 4, EE Ex. A)

Ms. Kane's deposition contains the vocational reports prepared by Ms. Gee from S& H (Exhibit 3 contained within Res.Ex. 4) In the first vocational assessment report, Ms. Gee stated that "based on Mr. McEvers's work history and education, he would have the following General Education Development (GED) on the scale of 1 to 6 with 6 being the highest: Reasoning Development – Level 3… Mathematical Development – Level 3 …. Language Development – Level 3." Report #1, page 10. A description of the skills associated with each of these levels was included in an attachment to the report (Report #1, page 14).

Per the report, the skills associated with Reasoning Development – Level 3 was "apply commonsense understanding to carry out instructions furnished in written, oral, or

diagrammatic form. Deal with problems involving several concrete variables in or from standardized situations." (Report #1, page 14)

Per the report, the skills associated with Mathematical Development – Level 3 was "Compute discount, interest, profit and loss; commission markup, and selling price; ratio and proportion; and percentage. Calculate surface, volumes, weights, and measures. Algebra: Calculate variables and formulas; monomials and polynomials; ratio and proportion variables; and square roots and radicals. Geometry: Calculate plane and solid figures, circumference, area, and volume. Understands kinds of angles and properties of pairs and angles." (Report #1, page 14)

Per the report, the skills associated with Language Development – Level 3 was "Reading: Read a variety of novel, magazines, atlases, and encyclopedias. Read safety rules, instruction in the use and maintenance of shop tools and equipment, and methods and procedures in mechanical drawing and layout work. Writing: Write reports and essays with proper format, punctuation, spelling, and grammar, using all parts of speech. Speaking: Speak before an audience with poise, voice control, and confidence, using correct English and well-modulated voice.

A review of the vocational reports show that Petitioner had difficulty understanding potential employers and the vocational consultant. Ms. Gee wrote on April 16, 2013, that "Mr. McEvers called me to discuss a job lead he had located at Southern Illinois University in Edwardsville (SIUE) for a Forklift Operator position. He did not have much information about it, other than to say he had spoken to Myra, at SIUE, and she was difficult for him to understand." (Report #3, page 2). In reference to the interview Petitioner had regarding selling insurance she wrote "On May 8, 2013, Mr. McEvers called me to update me regarding his interview. He could not remember the name of the company, but said they provide benefits to union employees. He said he had an interview for approximately 20 to 25 minutes. There were several people being interviewed this date. The job would be based out of Maryville, Illinois. Mr. McEvers said he did not always know what the interviewer was talking about, but he nodded and agreed with him when appropriate." (Report #3, page 8).

Petitioner had difficulty understanding the directions given to him by Ms. Gee. As an example, Petitioner said that he applied to one job online, but S&H had already applied to it on his behalf. On 7/19/13, he said that he applied to Home Depot after doing a follow-up call. (Report #6, page 3). Per his logs, it was posted on beyond.com. In the report, "he called Home Depot on July 5, 2013, and said he was told to apply online. I explained that I had applied on his behalf, so he was supposed to inquire about the

opening. Instead, he went online today, July 19, 2013, and said he submitted another application. I asked if they had an opening, and he said he did not ask." (Report #6, page 3). In reference to the computer classes he was taking Petitioner told Ms. Gee that he "has to read thing about three times for it to make sense." (Report #2, page 9). Ms. Gee had to advise Petitioner to print legibly on his applications and to "watch for the descriptive language he puts on applications." (Report #2, page 10). She had to tell him to apply to online applications in one setting and to use correct grammar and punctuation. (Report # 3, page 4). She found that he "frequently cusses during our conversations and I reminded him not to do so during the interview". (Report #5, page 6). In discussing her interactions with Petitioner Ms. Gee commented, "Mr. McEvers is not always clear when we are having discussions, so it was not until he was further explaining himself to me in this conversation that what he was saying made sense." (Report #6, page 5)

Part of the services Ms. Gee provided to Petitioner was to help him obtain computer skills. When they first met he told her that his computer skills were basic at best. He could turn on the computer and get into eBay and Google Map. He said he has a printer, but he does not know how to use it." (Report #1, page 7). He had never used e-mail nor had he ever had an e-mail address. He could not type except with one finger. (Report #1, page 6).

Ms. Gee hand-delivered a letter to Petitioner explaining how to access his email account at www.yahoo.com. When he had his computer with him, they would log in together so she could demonstrate how to bookmark accounts for easy access. She created an account for him on monster.com for job searches and uploaded his resume. He was asked to check his email daily and she showed him how to click on emails to look at the leads. Petitioner told her he had never had an email account before and had never really wanted one. She explained that not only would she communicate with him via email, but many employers also communicated via email. (Report #2, page 5).

In spite of her assistance Petitioner continued to have difficulty using his computer. Ms.Gee told him to contact her at any time at if he had questions or difficulty navigating sites. (Report #2, page 6). Ms.Gee reported that Petitioner did not have his own internet access but would use his neighbor's when it was available. He was trying to complete his computer classes and his job search activities around his neighbors schedule so he could have access to this internet. There were occasions when he would be up to 4:00 a.m. or 5:00 a.m. trying to complete classes because of the internet access. (Report #3, page 6,7& 9) Petitioner did not understand that he did not need to get a new e-mail address when he neighbor changed Internet companies not knowing that his Yahoo account could be accessed from any Internet carrier. (Report #2, page 9).

Petitioner expressed frustration regarding his computer classes. He would forget to log in to the classes and had to repeat them because he didn't get any credit without logging in. Ms. Gee had to repeatedly show him how to do that. (Report#2, page 7-9; Report #3, page 3.) He would work in the wrong lessons; Ms. Gee noted "Mr. McEvers said he had been reading lessons in Microsoft Word. I told him he was supposed to be working in Internet Basics. I reminded him I had provided a letter explaining how to log into the account, as well as the schedule of classes, and I also explained that he is now behind. In the course of our conversation, we agreed that we were going to add a class, Basic Computers, to his class schedule to be completed before he goes to Internet Basics. He said he was relieved, because he felt a little lost. He said that although he knows something about computers, it is not enough for him to be proficient and to get around very well." He told her he had to read things about three times for it to make sense. (Report #2, page 7,9)

Ms. Gee had to repeatedly help him sign into accounts on his computer. He would have difficulty finding the classes he was supposed to be taking. (Report #2, page 2 & Report #3, page 2). When he had difficulty accessing his email account she would do it for him and sent a copy of his cover letter and resume, as requested by any job leads. (Report #3, page 2). Ms. Gee provided letters to Petitioner including pictorials to try to help him with the process. (Report #3, page 4). On April 24, 2013, Petitioner left Ms. Gee a message that he was having trouble with his computer classes. She called him back, and noted that he "was having difficulty navigating the www.gcflearnfree.org web site after he completed his quiz for Computer Basics and earned a 100 percent. I talked to him while I was driving, but he was not understanding my explanations. I told him I would call him again in 30 minutes when I reached my destination and could access the Internet." She contacted him again "and we worked through his questions regarding his online computer classes. He was under the misconception that he had to take the quiz after each lesson not at the end of each class. I explained and walked him through how to find his next class. He has earned 100 percent on his quiz for Computer Basics and still has a couple of lessons to complete. He will then begin Internet Basics. He has worked on computer classes on and off all day today." (Report #3, page 5).

On April 26, 2013, Ms. Gee noted Petitioner had completed 100 percent of his Computer Basics class and achieved a 100 percent on the quiz after three attempts. He had completed 11 percent of the Internet Basics course. He had completed one lesson in the Internet Safety. On April 29, 2013, Ms. Gee and Petitioner spoke by phone. "He said he had to have his computer worked on beginning April 25, 2013, but he had determined that the problem was with logging into it. He said he was ready to go again in his

computer classes." (Report #3, page 6). On May 6, 2013, she reviewed Petitioner's computer classes, and he had completed Chrome, Computer Basics, Email 101, Internet 101, and Internet Safety. He achieved the following scores on his quizzes: Chrome: 100 percent; Computer Basics: 100 percent; Email 101: 100 percent; Internet 101: 80 percent; Internet Safety: 100 percent." (Report #3, page 12).

"On May 7, 2013, Ms. Gee noted that Petitioner still has some problems with knowing where to go with his computer classes, but he was better at navigating the site. He still forgets to log in, which means often his efforts are not documented completely and he must complete the lessons again." (Report #3, page 12). On May 15, 2013, Petitioner had completed Gmail and achieved 100 percent on the quiz. He had also completed Outlook 2003 and earned an 87 percent on the quiz." (Report #3, page 13).

On May 15, 2013, Ms. Gee called Petitioner. "He stated he had been working on his computer classes and has had problems, because of his poor connectivity to the Internet. He said he worked on his computer at home, as well as the computer at his daughter's house. Both had difficulty loading the website and he said it took forever. He said he was up working until 5:00 a.m. He said he was ready to begin the Microsoft Word section." (Report #3, page 9). On May 16, 2013, Ms. Gee contacted a job contact that Petitioner had identified. The assistant manager told her that there were openings, which could be applied for in person or online. Ms.Gee stated in her report, "Because Mr. McEvers has difficulty with accessing his computer and submitting online applications, I accessed this job lead on his behalf and submitted a job application for all three positions, as well as three equivalent positions in Jerseyville, Illinois." Report #3, page 17.

Ms. Gee asked Petitioner to change his phone greeting on his cell phone to a more professional greeting. On May 22, 2013, "Mr. McEvers discussed changing his phone greeting on his cell phone. He said it took him some time to get it changed, and after he did change it, he could not get his phone to work. He said he is using an old cell phone in the meantime. She suggested he turn the phone on and off to see if that fixed the problem. (Report #4, page 2-3). On June 17, 2013, Ms. Gee contacted Mr. McEvers by phone….."He said he had tried to get into his email account and could not access it. He asked if the passwords had been fixed so they didn't work over the weekend. I told him they had not, and that I had been in his account with no problem. I walked him through how to access the account, including telling his to go to www.yahoo.com rather than search for it on Google search bar. He said he would try again." (Report #4, page 9).

On June 7, 2013, Ms. Gee accessed Mr. McEvers' computer classes during their meeting and again, "I demonstrated on Mr. McEvers' computer how to open the Open Office program from his desktop. I showed him how to open a Word document, as well as an Excel document for when he gets to that section of his training. I walked him through a Word document and showed him how to save, change fonts, make text bold, underline text, how to print, how to highlight, etc. I demonstrated on the www.gcflearnfree.org training how similar this was, if not exactly the same as Microsoft Word. (Report #4, page 11).

On June 19, 2013, Ms. Gee and Mr. McEvers met. She noted that "Mr. McEvers had been telling me he could not access his email account because it would not accept his user name or password. I have been in his account multiple times. I demonstrated to him during our meeting how to access www.yahoo.com then how to enter his email address, then his password. We accessed his account with no issues. We reviewed his account on his computer during our meeting, opening some of his email. He said he received an email from AT&T stating he did not pass the assessment to move forward in the hiring process. I explained that many of the questions were about his proficiency with electronics and the computer and the answers needed to be honest. This is most likely what resulted in him in not getting an interview." (Report #5, page 3).

On June 20, 2013, Ms. Gee noted, "Mr. McEvers had completed 91 percent of Word 2007 and earned a 40 percent on his quiz after one attempt. He completed 21 of 23 lessons. I reviewed the classes later in the day, and Mr. McEvers had completed 100 percent of Word 2007 and earned 100 percent on his quiz after two attempts." (Report #5, page 11).

A review of the vocational materials reveal that Petitioner met in person with Ms. Gee eleven times from March 13, 2013 to August 1, 2013. They had many phone conversations. Ms. Gee wanted Petitioner to submit resume's or applications online and in person. She asked him to develop his own leads and to make follow up phone calls.

The vocational materials show that Ms. Gee developed 22 job leads for Petitioner. They included jobs for being a host, cashier or preparation person at Ponderosa, a cashier or bartender at Fanco, a cook helper at Thristy's Tavern or It's Charlie's, a packaging operator at Employment Solutions and many cashier positions at places like Moto Mart, Casey's General, Circle K and other convenience stores. Ms. Gee submitted 37 resume's on Petitioner's behalf. These were to places such as Land of Lincoln Goodwill, Home Depot, St.Anthony's Health Care, CVS Pharmacy, Caseys' and McDonald's to name a few. They were for such positions as sales associate, customer service representative,

maintenance, cashier, stock clerk, store manager, forklift driver and team member. Twelve resume's were submitted by Ms. Gee and Petitioner when they were at a meeting together. These were for positions such as sales associate, unarmed security guard, customer service specialist, cashier, security and fire officer, slot attendant, and part-time detailer.

According to his job logs and the vocational reports, from April 30, 2013 through August 1, 2013, Petitioner had 44 in person contacts or contacts in which he submitted a resume. These were to places such as It's Charlies, Thirsty's Tavern, Hardys, Scotty's, Casey's, Fanco, C & V Package Liquor, Shell Oil and Moto Mart. Thirty-one phone calls were made by the Petitioner to places like Discount House, Tri-county, Paradice Club, Moto Mart, Smoky's, Landes Trucking, CVS, Dollar General, Auto Zone and Staples. He made 15 additional contacts to employers such as Killian Communication, Casy's, Wallis Ice Service, Cooper's Car Clinic, Farmer Home Supply and CPS.

The deposition of Mr. Stephen Dolan was taken on behalf of the Petitioner on August 27, 2015. (Pet. Ex. 14). Mr. Dolan is a vocational counselor and met with the Petitioner on February 18, 2015. Mr. Dolan noted that Petitioner had a high school education, being a C minus student taking an extraordinarily number of vocational or shop classes in high school. He noted Petitioner told him he needed to do so in order to get enough credit to graduate. His only other formal education was one week of brake class training while he was still in high school. (Pet. Ex. 14 page 11). Mr. Dolan noted that Petitioner's past jobs all involved physical work. His past job experience included pumping gas, changing oil, repairing tires, repairing lawnmowers. He was a truck driver hauling pigs. He drove spreaders and sprayers fertilizing fields. He worked as a farm hand and he drove dump trucks and operated a bulldozer. His work also included changing tires on tractors or other agricultural equipment. (Pet. Ex. 14 page 12-14).

As far as the ability to use a computer Mr. Dolan testified that Petitioner did not know how to send or receive email, and had never used word processing software or spreadsheet software or bookkeeping software. (Pet. Ex. 14 page 22).

Mr. Dolan gave him the wide range achievement test (WRAT) which is a standardized test to see how well a person reads, spells and does math. He testified that Petitioner did not do those things very well. He recognized words at the sixth grade level, he comprehended sentences at the 10th grade level. That put him in a composite reading ability at the 10th percentile compared to other people in his age category of 45 through 54. He testified that what that means in the real world is that 90% of people his age read better than he does. He spelled at the third grade level which is the first

percentile so 99% of people his age spell better than he does and he did math at the fifth grade level which is the tenth percentile. That means 90% of people his age do math better than he does. Mr. Dolan testified that Petitioner's academic levels were below the range of average and his spelling ability which would affect his ability to write is more than two standard deviations below average. (Pet. Ex. 14 page 22-23).

As to Petitioner's residual vocational profile which is intended to be a snapshot of a person's employability, taking into account their age, their education, the results of testing, their work history and the restrictions by Dr. Wolters and from the functional capacity evaluation, Mr. Dolan testified Petitioner is a man approaching advanced vocational age. He has a high school diploma and reads at a tenth percentile, spells at the first percentile and does math at the tenth percentile. He has worked primarily as a truck driver and farm hand. He now cannot lift more than 30 pounds occasionally with his dominant arm and hand, 15 pounds frequently, 10 pounds constantly, and he has limitations regarding bending, right shoulder strength, standing, walking, and has pain with activity. (Pet. Ex. 14 page 23-24).

Mr. Dolan thought Petitioner had transferrable skills of commercial driving which would transfer absent the functional limitations to other types of commercial driving jobs. (Pet. Ex. 4 page 24).

Mr. Dolan reviewed vocational materials from when he was working with Ms. Gee. He noted the counselor had him take online computer classes to try to improve his computer use and she also completed applications online on his behalf as well as have Petitioner apply for jobs himself. The job search was not successful. Petitioner told Mr. Dolan the job search ended abruptly when he asked the counselor who was going to be liable if he had a traffic accident driving to look for a job while taking Oxycodone. (Pet. Ex. 14 page 25).

It was Mr. Dolan's opinion that the Petitioner is not employable in the open labor market. He testified that a person with the restrictions from Dr. Wolters would hypothetically be able to work but that there was simply no reason why someone was going to hire Petitioner with those restrictions as he would be looking for a job that he's never done. He would be competing against workers who are not only younger and workers who have full use of their dominant arm and hand, which he doesn't, workers who are not taking narcotic pain medication, which he is, and who read and write and do math much better than Petitioner. He testified there is simply no reason for someone to hire him and in his case the Oxycodone use seems to be a serious problem because he can't drive when he takes it. It makes him drowsy and causes a problem with

concentration. It was Mr. Dolan's opinion Petitioner would never pass a DOT physical to do driving over the road. (Pet. Ex. 14 page 25-26). It was also Mr. Dolan's opinion that there was no employment that would be regularly and continuously available to Petitioner in other words there would be no stable labor market available to him. (Pet. Ex. 14 page 27).

Mr. Dolan did not see Petitioner appealing to an employer as someone who greets the public or handles a front desk sort of capacity or even working in a fast food restaurant. He testified "I mean the last job he had, which he had for a number of years, he was hauling pigs, and he works and acts like someone who worked a long time hauling pigs. He is not going to be hired for any type of job where he is dealing with the public." (Pet. Ex. 14 page 26-28). Mr. Dolan did not think that even if he could find a job within his restrictions that Petitioner could maintain it. The narcotic use that he has would be a problem and having to lie down during significant parts of each day in order to keep his pain under control. Any activity increases his pain and if he is working his activity would of course increase. (Pet. Ex. 14 page 27-28). Mr. Dolan testified that Petitioner is very rough around the edges. (Pet. Ex. 14 page 33). Mr. Dolan did not think Petitioner was a candidate for any type of vocational retraining for the reason that he didn't think anybody was going to hire him. He was in too much pain and taking a strong narcotic pain medication. He testified he doesn't do very well on it and he is an older guy who doesn't read very well, write very well or do math very well so it would be a long haul to vocationally rehabilitate him. (Pet. Ex. 14 page 39). Mr. Dolan testified he put the most negative weight on Petitioner's limited ability to use his dominant arm and hand. His age certainly would be a negative factor with the limited ability to use the dominant upper extremity is a big one for people who do physical work. (Pet. Ex. 14 page 35).

The Petitioner was born on August 2, 1961. He was 48 years old on the date of his accident, 51 years old when he began vocational rehab with Ms. Gee and 56 years old at the time of arbitration.

In support of the Arbitrator's decision related to (J) medical services, the Arbitrator finds the following facts:

Petitioner alleges Respondent is liable for $127,667.07 in medical bills and submits the bills along with the medical records into evidence. A review of the records and bills show that most of the related bills have been paid by Respondent. The only unpaid medical appears to be two charges from Springfield Clinic, Dr. Richards for service in July and December 2015. Including out of pocket, the amounts owed total

$103.48. (PX 12) Respondent is ordered to pay that amount to the Petitioner pursuant to the Fee schedule.

In support of the Arbitrator's decision related to (K) Maintenance, the Arbitrator finds the following facts:

The Parties do not dispute that Petitioner was temporarily totally disabled from 5/26/10 through 1/25/13 representing 139 3/7 weeks. Petitioner alleges he is owed either maintenance or permanent total disability from 1/26/13 through the present (240 6/7 weeks). Respondent disputes this and alleges the proper period of payment is maintenance payments from 1/26/13 to 7/28/13 when they discontinued payments. The Arbitrator notes that once Respondent discontinued maintenance payments and discontinued vocational assistance Petitioner essentially stopped his job search other than checking with acquaintances he knew to see if they had any work he could do. As such, the Arbitrator finds Petitioner is not owed maintenance payments after 7/28/13.

Respondent is ordered to pay $472.55 per week for 165 5/7 weeks from 5/26/10 until 7/28/13 ($78,306.26), representing the TTD and maintenance owed.

The Respondent shall have credit for all amounts it paid, if any, to or on behalf of Petitioner on account of said injury.

In support of the Arbitrator's decision related to (L) nature and extent, the Arbitrator finds the following facts:

It is undisputed that Petitioner is unable to return to his previous employment at Craig Robers & Son Trucking. He sustained a serious injury and underwent significant medical treatment. He continues to treat regularly with physicians for pain control and has been given permanent restrictions. Petitioner testified credibly as to his ongoing complaints and the functional problems he continues to have and those complaints have been documented in the medical records and by his treating physicians. There has not been any suggestion by any of the treating physicians that Petitioner is manufacturing his complaints or that they are not explained by the injury he sustained and the treatment he received.

Petitioner underwent a job search directed by a vocational counselor. He was only able to secure two job interviews and did not receive any offers. Approximately 139 contacts were made with potential employers either through online applications, in person visits or phone calls. Petitioner would receive online responses from prospective employers acknowledging the applications but did not receive calls for interviews or job

offers. Throughout the process the vocational counselor expressed concerns over Petitioner's cooperation with her directions. She listed as concerns a lack of follow-up on his part, that he didn't return phone calls, that he didn't meet the minimum requirement of employer contacts.

Petitioner fits the "fish out of water" proverb. He has spent all of his life living in a rural community doing laborer's work. Before his injury he never had to look for a job as he always obtained work through word of mouth among his acquaintances. He told the vocational counselor he had only participated in one interview his whole life.

Mr. Dolan testified that Petitioner is very rough around the edges. The vocational counselor had to instruct him on how to dress, speak and interact with potential employers. Petitioner was observed at trial. He is missing his front teeth. In the vocational assistance process he had to be reminded to use proper grammar and punctuation on job applications. Ms. Gee noted he cussed a lot and asked him to try not to use any bad language during any interviews. He is only used to dressing very casually, typically wears a baseball cap and doesn't own a suit.

Ms. Gee and Ms. Kane asserted that from Petitioner's past work experience he would have the mathematical ability to compute discount, interest, profit and loss etc. and that he would be able to write reports and essays with proper format, punctuation, spelling and grammar. He would be able to speak before an audience with poise, voice control, and confidence, using correct English and a well-modulated voice. The Petitioner does not have those abilities. In his past work experience he had only had to use basic math, he never had to prepare reports, never used a computer and didn't deal with the general public.

The fact Petitioner is not capable of those type of activities is further confirmed by the difficulty he had during the vocational process in trying to understand how to use his computer for his job searches and computer courses. He continually had trouble logging into his programs, could not figure out how to apply for jobs on line and had to receive repeated instruction from Ms. Gee on how to do those tasks.

The vocational counselors were identifying jobs for Petitioner in which he would have to deal with the public on a regular basis such as cashiers, customer service, sales. Petitioner has no like past work experience. Mr. Dolan did not see Petitioner appealing to an employer as someone who greets the public or handles a front desk sort of capacity or even working in a fast food restaurant. He testified "I mean the last job he had, which he had for a number of years, he was hauling pigs, and he works and acts like someone

who worked a long time hauling pigs. He is not going to be hired for any type of job where he is dealing with the public." (Pet. Ex. 14 page 26-28). Mr. Dolan did not think that even if he could find a job within his restrictions that Petitioner could maintain it. The narcotic use that he has would be a problem as well as having to lie down during significant parts of each day in order to keep his pain under control. Ms. Gee herself commented that Petitioner was not always clear when they were having discussions and it was not until he would further explain himself that what he was saying made sense.

While the Arbitrator sees that the Petitioner was not always diligent in following through on the tasks he was asked to do by the vocational counselor the Arbitrator does find Petitioner probably did the best job he was capable of doing. As to the jobs suggested by Respondent's vocational experts as being available and appropriate for Petitioner, the Arbitrator agrees with Mr. Dolan that no employer is going to find Petitioner appealing for those positions. These include jobs such as customer service positions, fast food positions, cashier positions and sales positions. It is important to note that many of those jobs were applied to and Petitioner only received two interviews and no offers. As such, the Arbitrator finds compelling the testimony of Mr. Dolan who testified that he did not think Petitioner was employable in the open labor market and there was no reasonably stable labor market for the Petitioner.

The Appellate Court has stated on a number of occasions that there are three ways in which one can prove entitlement to permanent total disability on an "odd lot" basis. One would be by a preponderance of the medical evidence. Here, the medical evidence does not show the petitioner to be unemployable. The opinions of Dr. Wolters along with the valid FCE results show that the Petitioner could perform work in the Light to Medium exertional levels. As stated above, it is also true that the restrictions would prevent him from performing his past work.

The second way to prove entitlement to benefits would be by showing a diligent but unsuccessful job search. In this case, the answer to this question must blend in with the answer to the question as to whether the Petitioner has proven entitlement under the third method of proof, namely whether he has demonstrated that, because of age, training, education, experience, and condition, there are no available jobs for a person in his condition. Professional Transportation, Inc. v. IWCC, 966 N. E. 2d 40 (2012).

The Arbitrator believes that the Petitioner's job search was less than diligent, looking at it on an objective basis. However, he believes further that the reason that it was less than diligent was because the evidence established that his lack of education prevented him from doing much if any more in an effort to find a job. Again, the

18IWCC0356

Arbitrator finds persuasive the opinions of Mr. Dolan noted above. Also, the argument made that the Petitioner did not look for work because he was receiving social security disability benefits is not well founded. When he began working with Ms. Gee on March 15, 2013, his was not receiving SSD, having been turned down twice. Ms. Gee's reports do not indicate that he was approved for benefits until June 18, 2013. By then, her reports indicated that the Petitioner had problems understanding his computer classes. Nonetheless, her reports indicate that between June 18 and July 15, 2013, the Petitioner did complete his computer classes. This indicates his willingness to continue to try and participate in voc rehab despite being approved for SSD benefits.

The evidence establishes that the Petitioner is permanently and totally disabled under the third test explained by the Court in Professional Transportation.

In support of the Arbitrator's decision related to (O) mileage, the Arbitrator finds the following facts:

Petitioner is seeking mileage related to travel associated with both his vocational rehabilitation and medical treatment. First, it should be pointed out that Petitioner did not admit into evidence any mileage or travel logs in support of his travel associated with either his medical treatment or participation in vocational rehabilitation. Petitioner testified that each trip to meet with Ms. Gee in Jerseyville was approximately 50 miles round trip, but that he had no idea how many trips he made. Petitioner also testified he made in person contacts with potential employers in Jacksonville, Jerseyville, Winchester, East Hardin, Eldred and St. Louis, but again has no idea how may trips he made. Petitioner testified he attended physical therapy in Jerseyville and went to both Springfield Clinic and Memorial Medical Center in Springfield for treatment.

There is no provision in the Act that specifically addresses reimbursing an employee for mileage for medical treatment or vocational rehabilitation. Case law has held that for mileage associated with medical treatment to be reimbursed, Petitioner is required to show that he had to travel outside his local area (more than 100 miles round trip) to get reasonable and necessary medical treatment. *Frey v. Aldi, Inc.*, 09 IWCC 0061 (2009) citing *General Tire & Rubber Co.*, 221 Ill.App.3d 641, 582 N.E.2d 744 (1991). The same rule was applied by the Commission to mileage expenses for vocational rehabilitation in *Ruth Lindley v. Southeastern Special Education*, 15 WC 0850.

Petitioner lives in White Hall, Illinois. Petitioner testified he traveled 50 miles round trip to meet with Ms. Gee in Jerseyville. He also testified he traveled to Jacksonville, Jerseyville, Winchester, East Hardin, Eldred, and St. Louis to make in person employer contacts. A Google Maps search confirms that from Petitioner's home in White Hall, the only trip that would have exceeded 100 miles round trip was

the trip to St. Louis. However, there is no documentation admitted into evidence to support that Petitioner actually visited an employer in St. Louis, MO. As Petitioner's travel associated with vocational rehabilitation qualifies as local travel pursuant to case law, Petitioner's demand for mileage reimbursement associated with vocational rehabilitation is denied in its entirety.

Mileage reimbursement associated with Petitioner's local medical treatment is denied. As noted above, Petitioner's travel to Jerseyville is local travel and is therefore not reimbursable related to his physical therapy

Additionally, Petitioner is requesting reimbursement for mileage expenses for trips he made outside of his home town traveling and Springfield, Illinois to treat with Dr. Wolters, Dr. Pineda and Dr. Richards and to attend therapy.

Since his release from Dr. Wolters, Petitioner has had to travel to Springfield to pick up his prescription from Dr. Richard's office. This is because he is on a narcotic medication and that medication must be closely monitored. Dr. Richard's office is located at 1100 Centre West Dr. Springfield, IL which is a 108 mile round trip for Petitioner. Petitioner presented no evidence of the number of trips made to Dr. Richards besides the doctor's treatment notes. They show a total of 9 office visits between Jan. 8, 2014 and Dec. 29, 2015, which totals 972 miles.

After his injury Petitioner had to seek care in Springfield, Ill as there were no similar specialists in his home town. He would travel to see Dr. Pineda and Dr. Wolters at the Springfield Clinic on 800 N. 1st Street in Springfield, Ill or at 1025 S. Sixth Street in Springfield, Ill resulting in a 112 mile round trip for the Petitioner. A review of the medical evidence reveals Petitioner made 34 visits to these facilities (3808 miles)

Petitioner had FCE testing over two days at Memorial Industrial Rehab located at 775 Engineering Ave, Springfield, IL a 115 mile round trip (230 miles). He attended work hardening for thirty visits at Midwest Rehab located at 1301 S. Koke Mill Rd. Springfield, IL, a 107 mile round trip. (3210 miles)

Petitioner is entitled to be reimbursed for mileage for travel made for non local treatment outside of his home town. Petitioner has traveled a total of 8220 miles which is in mileage expenses incidental to his medical treatment. The 2017 IRS reimbursement rate is .535 cents per mile, bringing the total awarded to $8220.54.

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STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAUL FRED,

Petitioner,

vs.

NO: 12 WC 26843

18IWCC0357

DUQUOIN HOME LUMBER ,

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, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

For reasons stated in Decision 13 WC 10931, the Commission finds the Petitioner credible. The Commission otherwise affirms and adopts all else.

IT IS THEREFORE ORDERED BY THE COMMISSION, that the Decision of the Arbitrator filed August 17, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

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

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

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

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party commencing the 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 - 2018

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 4/16/18
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FRED, PAUL S
Employee/Petitioner

Case# **12WC026843**

12WC026857
13WC010760
13WC010931

DuQUOIN HOME LUMBER
Employer/Respondent

18IWCC0357

On 8/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

0693 FEIRICH MAGER GREEN RYAN
D BRIAN SMITH
PO BOX 1570
CARBONDALE, IL 62903

0283 JELLIFFE FERRELL DOERGE ET AL
KELLY R PHELPS
108 E WALNUT PO BOX 406
HARRISBURG, IL 62946-0406

18IWCC0357

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

Paul S. Fred
Employee/Petitioner

v.

DuQuoin Home Lumber
Employer/Respondent

Case # **12 WC 26843**

Consolidated cases: 12 WC 26857, 13 WC 10760, 13 WC 10931

An *Application for Adjustment 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 **June 13, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 3, 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.

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

In the year preceding the injury, Petitioner earned $**21,621.60**; the average weekly wage was $**415.80**.

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

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

Respondent ***is*** entitled to a general credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he sustained an accident on December 3, 2010 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being is causally connected to the alleged injury. 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.

Nancy Lindsay
Signature of Arbitrator

August 12, 2017
Date

AUG 17 2017

Paul S. Fred v. Du Quoin Home Lumber, 12-WC-026843

Findings of Fact and Conclusions of Law

Petitioner originally had eight claims pending against Respondent. Four of these claims were dismissed at the time of arbitration. The remaining four cases went to arbitration with the parties understanding that separate decisions would issue for each claim. Petitioner alleges an accident date of December 3, 2010 in this particular claim.

The Arbitrator finds:

Petitioner's medical records date back to 2002. On December 4, 2002, Petitioner was seen at DuQuoin Chiropractic Center. Petitioner's Patient Information Form references an injury date of December 2, 2002 which was job-related. (PX 4; RX 3) Petitioner was complaining of neck stiffness and headaches. A history of having been bucked off a horse and left shoulder complaints stemming from "extensive overuse of the left arm" was noted. According to the note, "this all happened about a year ago." Dr. Eaton also noted that Petitioner had occasional back pain described as "crampyness [sic]." (PX 4; RX 3)

Petitioner continued to see Dr. Eaton on six occasions in December of 2002 regarding his left shoulder, left index finger, and mid-back. (PX 4; RX 3)

Petitioner returned to see Dr. Eaton on February 26, 2007, having last been seen there in December of 2002. Petitioner was very sore in the L4-S1 levels and was having difficulty walking, with his symptoms in his low back having been steadily getting worse for the preceding 3 – 4 days. Petitioner continued to see Dr. Eaton in February and March of 2007. Dr. Eaton noted Petitioner's need to periodically sit at work every hour or so and then the pain would stop. Petitioner was also noted to be doing housework and riding his horse, although not very fast. On March 28, 2007 Dr. Eaton noted that Petitioner had been very sore the day before after moving some shingles. (PX 4; RX 3)

Petitioner continued to see Dr. Eaton in April and May of 2007. (PX 4; RX 3) On May 11, 2007, Petitioner reported he was steadily improving and had been very active the previous week. On May 18, 2007, Petitioner reported he was continuing to improve, and that he was performing nearly his normal work duties with only a dull ache. On May 25, 2007, Petitioner reported doing his normal work, which included moving shingles and sheetrock, with very little difficulty.

Petitioner was seen by Dr. Eaton three (3) times in June of 2007 reporting only minimal symptoms consisting of a dull ache on June 1, 8, 22, and July 6, 2007. On July 6th Petitioner reported doing very well and working long days with lots of heavy lifting and experiencing only a dull ache rather than any sharp pain. (PX 4 at 6, RX 3)

On July 16, 2007, Petitioner reported to Dr. Eaton that his low back was very painful after performing heavy lifting. (PX4 at 5). He also reported bilateral leg pain on this date.

Petitioner was seen on July 17, 20, and 24, 2007, complaining of a painful low back. On the 20th he associated his pain with lifting his granddaughter. (PX 4; RX 3)

By July 27, 2007, Dr. Eaton noted Petitioner was doing much better. (PX4 at 5). On August 10, 2007, Petitioner reported only occasional dull aching with no sharp pain despite working very hard at work performing lots of lifting. (PX 4; RX 3)

On September 7, 2007, Petitioner returned to see Dr. Eaton reporting that he was doing very well with only occasional dull aching and no sharp pain. (PX 4; RX 3)

Petitioner was not seen again by Dr. Eaton until September 23, 2008, more than a year following his last visit. (PX4 at 5). Dr. Eaton's note described low back pain beginning approximately three weeks earlier on the left after moving 2x8s at work. He stated the pain dissipated two or three days thereafter with the use of ice, but had returned approximately two weeks earlier to the visit, and included right-sided dull pain radiating to the front side of his leg to his knee. (PX 4; RX 3)

Thereafter Petitioner continued his chiropractic treatment with Dr. Eaton with an additional two visits in September of 2008 and four (4) visits in October of 2008. (PX4 at 4-5; RX 3) As of September 29, 2008, Petitioner felt 90 percent better with an occasional sharp pain when "twisting wrong." During the October visits, Petitioner reported only dull aching or intermittent sharp pain following walking and lifting.

Petitioner returned to see Dr. Eaton on March 8, 2010, having last been seen in October of 2008. Dr. Eaton noted Petitioner had very severe lower back pain and left sacroiliac joint pain. He was having difficulty walking but denied any radiating pain. On March 9, 2010 Dr. Eaton noted no significant change in Petitioner's condition. He still had difficulty walking and sleeping. Dr. Eaton wrote, "He has steadily been getting worse for about 3 weeks but no specific injury to cause it." (RX 4)

Records from Wittenauer Chiropractic, located in Pinckneyville, Illinois, indicate that Petitioner was seen one (1) time for chiropractic treatment on March 30, 2010. (PX5 at 4[1]) According to a general information sheet, Petitioner was there due to neck and back pain. He gave an onset date of "three weeks ago." (RX 4) He denied that the condition was getting worse but indicated that it interfered with his work, sleep, and daily routines. In response to the question "Have you had this or similar conditions in the past?" Petitioner marked "Yes" and noted "Just lower back." (RX 4) When seen by the doctor, Petitioner complained of left sacroiliac and left lower back pain, rating both at 6 out of 10. When asked what aggravated his problem, he responded "it is when he bends and lifts too much." Petitioner also reported that his problems became better when he used NSAIDs and rested. (PX 5 at 4) Petitioner was moderately tender over his left sacroiliac articulation. In the prone position, a functionally short right leg length was noted. An onset date of February 28, 2010 was also noted. (RX 4)

[1] See also RX 4, a copy of Wittenaur Chiropractic records.

According to Respondent's delivery records, on December 1, 2010 Petitioner made deliveries to the old Baptist Church, Searby Funeral Home, DQ High School, and Dave Kent. (RX 7)

According to Respondent's delivery records, on December 2, 2010 Petitioner made deliveries to Jackie Davision, Terry Marks, Brad Galli, John Tilley, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 3, 2010 Petitioner made deliveries to Steve Eisenhauer, McPherson Auto, and Terry Marks (Job – Alongi's). (RX 7; PX 10)

According to Respondent's delivery records, on December 4, 2010 Petitioner made deliveries to Doug Hill, Steve Epplin, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 6, 2010 Petitioner made a delivery to Eric W. (RX 7)

According to Respondent's delivery records, on December 7, 2010 Petitioner made deliveries to Carl Goldman and Dave Kent. (RX 7)

According to Respondent's delivery records, on December 8, 2010, Petitioner made deliveries to Kenny Heape and Pete Daumond. (RX 7)

According to Respondent's delivery records, on December 9, 2010 Petitioner made deliveries to Terry Marks, Gary Dickerson, Joel Tolliver, Steve Eisenhauer, P.C.H.A., Gerald Weeks, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 10, 2010 Petitioner made deliveries to Chris Albers, Steve Eisenhauer, Pinckneyville High School, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 13, 2010 Petitioner made a delivery to Tom Denton. (RX 7)

According to Respondent's delivery records, on December 14, 2010 Petitioner made a delivery to Steve Eisenhauer. (RX 7)

According to Respondent's delivery records, on December 15, 2010 Petitioner made deliveries to Carl Goldman and Absolute Construction. (RX 7)

According to Respondent's delivery records, on December 16, 2010 Petitioner made two deliveries to Jackie Davision. (RX 7)

According to Respondent's delivery records, on December 17, 2010 Petitioner made a delivery to Matt Milam, the Elks Club, and Ron Davis. (RX 7)

According to Respondent's delivery records, on December 20, 2010 Petitioner made a delivery to Gene Creek, Chase Porter and Dave Kent. (RX 7)

According to Respondent's delivery records, on December 21, 2010 Petitioner made a delivery to Monte Kuhnert, Carl Goldman, Chase Porter, and Taylor Brothers. (RX 7)

According to Respondent's delivery records, on December 22, 2010 Petitioner made a delivery to "5 - Star." (RX 7)

According to Respondent's delivery records, on December 23, 2010 Petitioner made a delivery to Carl Goldman. (PX 11)

According to Respondent's delivery records, on January 4, 2011 Petitioner made a delivery to Amanda Dearmond, Mark Roznowki, and Graham's Painting. (RX 7)

According to Respondent's delivery records, on January 11, 2011 Petitioner made a delivery to Kellerman's Powder Coat. (RX 7)

On January 13, 2011 Petitioner returned to Wittenauer Chiropractic, having last been seen in March of 2010 and described a "new problem" of right-sided sacroiliac and sciatic pain that he rated at 10 out of 10. Dr. Wittenauer also wrote "The patient's diagnosis from Thursday, December 30, 2010, was amended today." The note also contains a date of onset of December 30, 2010. When asked what made the problem worse, Petitioner responded that "it's worse when he does nothing in particular because it is always there." Petitioner also reported that nothing was relieving his problems. (PX 5; RX 4)

On January 14, 2011, Petitioner returned to Wittenauer Clinic, reporting that he was doing better but also complaining of 9 out of 10 right sacroiliac and right sciatic pain. He underwent chiropractic treatment on that date. Petitioner was advised to return as needed. (PX 5 at 2)

On January 26, 2011, Petitioner was seen by Dr. Douglas Cochran, Tri-County Chiropractic Centre, in Du Quoin, Illinois. (PX3 at 17) Petitioner completed a "New Patient Case History" form. He indicated that his chief complaint was right-sided back pain and pain down his right leg. He claimed his injuries were due to an on-the-job injury but he left the date of accident blank and stated that he didn't intend to turn it in to workers' compensation. (PX 3 at 19) Dr. Cochran noted that Petitioner had been experiencing severe lower back pain and right lower extremity pain for several weeks and had been unable to work for the past two weeks due to his pain. Petitioner stated he first noticed his pain after lifting drywall and that this had happened before but was getting worse. His pain was located in his L3 to S1 region, as well as his right upper anterior thigh. He rated his pain at 8-9 out of 10. Dr. Cochran suspected a lumbar discopathy based upon lumbar x-rays which revealed mild degenerative changes throughout Petitioner's lumbar spine. His physical exam yielded a positive straight leg raise test on the right, positive Lasegue's and Braggard's tests on the right, and right quadriceps weakness. (PX3 at 18) Dr. Cochran assessed Petitioner with lumbar discopathy on this date, which he characterized as a "new condition." (PX3 at 15)

Petitioner returned to Dr. Cochran for four (4) chiropractic treatments in January and February of 2011, before Dr. Cochran referred Petitioner for an MRI of his lumbar spine. (PX3 at 2-14) Petitioner did not return to Dr. Cochran following his MRI. (PX3).

On February 8, 2011, Petitioner underwent a lumbar MRI at Cedar Court Imaging, in Carbondale, Illinois. (PX 3; PX6) The MRI revealed a disc protrusion or mild herniation at L2-3 in the right paracentral region of the spinal canal extending toward the right foramine, resulting in moderate to severe spinal stenosis and right foraminal stenosis. (PX6 at 2) There was asymmetric disc bulging at L3-4 toward the right. At L4-5, there was moderate to prominent left facet arthropathy indenting and compressing the left lateral and left posterolateral aspects of the thecal sac. At L5-S1, there was asymmetric bulging of the disc centrally and posterolaterally toward the left extending into the inferior left foramine. Summarily, Petitioner had evidence of multilevel disc disease with areas of spinal stenosis and foraminal stenosis as noted in the findings.

On February 23, 2011, Petitioner was seen by a physician's assistant at the office of neurosurgeon Dr. Franklin Hayward, Heartland Spine, in Marion, Illinois. (PX9 at 25[2]) Petitioner had been referred by Dr. Furry for his lower back, right hip, and leg pain. According to the note "This started in January 2011." Petitioner had tried conservative treatment but had not experienced any relief. Dr. Hayward's note documented decreased range of motion, paralumbar tenderness, sciatic nerve tenderness on the right, and positive straight leg testing on the right. (PX9 at 25) Dr. Hayward's note also noted decreased sensation in the S1 distribution. Per the MRI, Petitioner was felt to have a disc protrusion asymmetric towards the left along with multilevel disc bulging and degeneration. He noted a disc protrusion at L5-S1 touching the exiting nerve root, and assessed Petitioner with right L5-S1 radiculopathy. He referred Petitioner for an epidural steroid injection.

On March 2, 2011, Petitioner was seen at Southern Illinois Pain Management, Marion, Illinois, by Dr. Julie Sowerby. (PX8 at 8-11; RX 6) Petitioner described his problem as right leg numbness and aching, right foot burning, aching, and numbness and chronic burning and stabbing pain in his lumbar region and right buttock. Petitioner described the aggravating factors as sleep/rest, sitting and walking. In the narrative portion of the report, the doctor stated:

> [Petitioner] has a quite physical job working for a lumber yard. He reports that he has noticed gradually increasing back pain with the work that he does over a number of years. He states that he is a delivery person, and has to lift and move packets of shingles, which are quite heavy. He reports that his back pain began upon awakening from sleep on January 12, 2011. He did not have any new injury or trauma at that time. He does note difficulty performing his job duties due to his low back and leg pain. .....He states that prior to this morning in January when he awakened with pain, he did not have the leg symptoms that he currently has. … (RX 6)

[2] See also RX 5.

Dr. Sowerby noted Petitioner had difficulty with driving, leisure activities, sleeping, standing, walking, working, yard work, lifting and driving a car. Petitioner was diagnosed with facet arthropathy (spondylosis), without myelopathy, low back pain, lumbar degenerative disc disease and spinal stenosis. He was scheduled for an epidural steroid injection. He was also told to continue his Advil and she added Gabapentin. (PX8 at 10; RX 6).

Petitioner underwent an epidural steroid injection at L5-S1 on March 7, 2011, performed by Dr. Paul Juergens at Southern Illinois Pain Management. (PX8 at 7)

On March 22, 2011, Petitioner returned to Southern Illinois Pain Management reporting no relief from his pain, although he felt the numbness and tingling in his right foot was a little better. (PX8 at 5; RX 6)

On March 28, 2011, Petitioner underwent a second epidural steroid injection at L5-S1 slightly to the right of midline. (PX8 at 4)

On April 13, 2011, Petitioner returned to Southern Illinois Pain Management reporting a little relief following the injections, but also describing his condition as worsening. Petitioner told the PA that he would prefer to follow up with Dr. Hayward rather than undergo another injection. (PX8 at 2; RX 6)

On April 27, 2011, Petitioner returned to see Dr. Hayward's PA-C, Chris Hodges. (PX9 at 24) The note documented only temporary relief following injections. Petitioner was noted to have predominantly right lower extremity pain although some prior back pain in previous months had included the left lower extremity. Petitioner reported being unable to work due to discomfort. Petitioner still had sensory changes in the L5 distribution. Petitioner was not able to tolerate his symptoms, and wished to discuss surgical intervention with Dr. Hayward. (PX 9; RX 5)

On May 7, 2011, Petitioner was seen by Dr. Hayward. (PX9 at 23; RX 5) Petitioner's subjective complaints included continuing right leg pain, primarily below the calf and right foot, seemingly in the L5-S1 distribution. Dr. Hayward noted moderate to severe foraminal narrowing at L4-5 and L5-S1 on the left compressing the exiting nerve roots, and Petitioner's greatest areas of foraminal narrowing occurred at L2-3 and L4-5 on the right. Dr. Hayward referred Petitioner for a lumbar myelogram and post myelogram CT, and flexion/extension x-rays of the lumbar spine.

On May 18, 2011, Petitioner underwent a lumbar myelogram and post myelogram CT at Memorial Hospital of Carbondale. (PX7 at 26-27; 30-31) The lumbar CT revealed disc herniations at L2-3 and L3-4 lateralizing to the right, severe degenerative changes to the facet joints at L4-5, and a mild disc bulge at L4-5 as well as minimal anterolisthesis, and a disc bulge at L5-S1. (PX7 at 26-27) Lumbar x-rays from the same date confirmed the presence of spondylolisthesis at L4-5. (PX7 at 28)

On May 25, 2011, Petitioner returned to Dr. Hayward; however, due to a tornado warning, Dr. Hayward was unable to review Petitioner's CT myelogram. (PX9 at 16; RX 5). Dr. Hayward indicated his intent to speak with Petitioner later by telephone. Dr. Hayward noted that Petitioner was walking with an antalgic gait. He documented complaints of severe right leg pain with pain radiating into both the L4-5 and L5-S1 distributions. Dr. Hayward felt Petitioner would probably need a facetectomy with diskectomy, interbody spacer at L4-5, and L5-S1 with instrumentation and SSEP monitoring. (RX 5)

On May 27, 2011, Petitioner was again seen by Dr. Hayward. (PX9 at 15) Dr. Hayward noted the lumbar myelogram showed an L4-5 and L5-S1 right radiculopathy as well as low back pain related to his degeneration and facet arthropathy and neural foraminal stenosis. Petitioner was noted to have bilateral spondylitis at L4-5 and Grade 1 spondylolisthesis at L4-5. Dr. Hayward recommended a transforaminal lumbar interbody fusion at L4-5 and L5-S1 on the right, and decompression and discectomy at L2-3 and L3-4 on the right. Dr. Hayward wrote, "I feel that the patient's Grade 1 spondylolisthesis at L4-5 and disc desiccation at L4-5 and L5-S1 is causing his low back pain." He also noted that Petitioner had a combination of disc/osteophyte complex at multiple levels. Dr. Hayward chose not to perform a fusion at L2-3 and L3-4 due to the risk of adjacent segment disease although he noted a considerable amount of foraminal narrowing due to facet hypertrophy at those levels. (RX 5)

On June 23, 2011, Dr. Hayward performed transforaminal interbody fusions at L4-5 and L5-S1 on the right with laminectomy and discectomy at L3-4 on the right and a laminectomy at L2-3 on the right. (PX9 at 11)

On July 18, 2011 Dr. Eaton issued a note pertaining to Petitioner and his recent back surgery. Dr. Eaton indicated that he had last seen Petitioner on March 11, 2010 and had no knowledge as to his current condition. (PX 4)

On July 22, 2011, Petitioner returned to Dr. Hayward reporting dramatically improved leg and ankle pain. X-rays demonstrated excellent placement of the hardware and spacer. Dr. Hayward referred Petitioner for physical therapy. (PX 9 at 9)

In a note dated August 8, 2011, Dr. Eaton discussed payment of his bills, indicating that Bruce Zoller had paid a total of $600.00 for treatment Petitioner had received from "2-23-12[sic][3] thru 9-7-07." He also wrote that he had treated Petitioner seven times between September 23, 2008 and October 31, 2008 for which Bruce Zoller had paid $188.00. (PX 4)

On September 2, 2011, Petitioner returned to Dr. Hayward, who described Petitioner as "ecstatic" and very pleased with the outcome of his surgery. Petitioner was doing great. He wished to ride his horse but was told not to do so. (PX9 at 7) He was released to drive and instructed to wean out of his brace completely. Petitioner's leg pain was reportedly completely resolved, and Petitioner was no longer taking pain medication. Petitioner declined additional physical therapy and was told to return in twelve weeks for a CT scan.

[3] Should be 2/26/07

On November 14, 2011, Petitioner underwent a CT scan of his lumbar spine, without contrast, performed at Memorial Hospital of Carbondale. (PX7 at 9) The CT scan showed, *inter alia*, questionable spinal nerve root impingement that was not definitively excluded. (PX7 at 10)

On November 22, 2011, Petitioner was seen by Dr. Hayward, who reviewed the CT scan and stated it showed some evidence of bony growth particularly along the facet joints and around the screws, but there was some bone growth within the spacers that was not yet complete. Petitioner described his pain level as a "1" at most. He was noted to be doing extremely well. (PX9 at 4) Dr. Hayward recommended Petitioner return in six to eight months for a repeat CT scan. Dr. Hayward noted that as of January 1, 2012, Petitioner would not be able to afford any additional tests or procedures due to the high co-pay and Dr. Hayward stated he would settle on an x-ray.

On June 22, 2012, Petitioner returned to see Dr. Hayward. (PX9 at 3) Petitioner was reportedly doing extremely well. He had some pain complaints but described them as tolerable. He also reported some limitations with daily activities. X-rays demonstrated good placement of screws and alignment of the lumbar spine. Dr. Hayward recommended Petitioner follow up in one year with a CT scan and flexion/extension films of the lumbar spine, at which point Dr. Hayward stated he would most likely release Petitioner. Petitioner also requested a State of Illinois Disability Identification Card which the doctor signed, indicating Petitioner was at "Class 2." Petitioner did not return to Dr. Vaught's office following this visit. (PX9)

Petitioner has undergone no further medical treatment for his low back since June 22, 2012.

On August 6, 2012, Petitioner's Application for Adjustment of Claim in case #12 WC 26843 (this claim) was filed. Petitioner alleged an accident date of December 1, 2010 when he was "lifting sheet rock and roofing shingles to customer, Alongi's Restaurant, in the regular course of employment." (AX 2, RX 1)

On August 6, 2012, Petitioner's Application for Adjustment of Claim in case # 12 WC 26857 was filed. Petitioner alleged an accident date of "February 2007" due to "loading and unloading of sheet rock and roofing shingles in the regular course of employment." (AX 4, RX 1)

On September 27, 2012 Petitioner's Application for Adjustment of Claim in case # 12 WC 33621 was filed. Petitioner alleged an accident date of March 1, 2011.[4] (IWCC website)

On September 27, 2012 Petitioner's Application for Adjustment of Claim in case # 12 WC 33656 was filed. Petitioner alleged an accident date of January 12, 2011 due to "repetitive trauma from loading and unloading of sheet rock and roofing shingles in the regular course of employment." (IWCC website; RX 1)

[4] RX 1 contains an unfiled/unnumbered Application for Adjustment of Claim with an accident date of "December 2010." This may be the same claim with injuries being attributed to "loading and unloading of sheet rock and roofing shingles."

On April 2, 2013 Petitioner's Application for Adjustment of Claim in this case (# 13 WC 10760) was filed. Petitioner alleged an accident date of September 2, 2008 while "lifting 2 X 8 pieces of lumber in the regular course of employment." (AX 6; RX 1)

On April 3, 2013 Petitioner's Application for Adjustment of Claim in case # 13 WC 10931 was filed. Petitioner alleged an accident date of January 4, 2011 due to "lifting in the regular course of employment." (AX 8; RX 1)

On April 3, 2013 Petitioner's Application for Adjustment of Claim in case # 13 WC 10922 was filed. Petitioner alleged an accident date of January 11, 2011 due to "repetitive trauma from loading and unloading building materials in the course of employment." (IWCC website; RX 1)

On April 3, 2013 Petitioner's Application for Adjustment of Claim in case # 13 WC 10928 was filed. Petitioner alleged an accident date of December 7, 2010 due to "repetitive trauma from loading and unloading of sheet rock and other building materials at the residence of customer, Carl Goldman, in the regular course of employment." (IWCC website; RX 1)

Report and Deposition of Dr. Vaught

By letter dated February 12, 2015 Petitioner's attorneys wrote to Dr. Kevin Vaught about the records review he had agreed to perform. The letter referenced all of Petitioner's pending accident dates. Counsel advised Dr. Vaught that it "was their belief" that Petitioner's symptoms were caused or aggravated by two separate incidents while Petitioner was working for Respondent in December of 2010 and/or January of 2011. According to the letter:

> The first injury occurred while [Petitioner] was picking up returned sheet rock from a customer's house. Six or seven sheets were returned. The sheet rock was four by twelve and 5/8 of an inch in width. Each sheet weighed approximately 100 pounds, and the package contained two sheets. [Petitioner] informed us he had to stoop to maneuver the sheet rock through the doorways of the house, and coming out of the house he felt a burning sensation in his low back.
>
> The second injury occurred when [Petitioner] was delivering the same size sheet rock to a restaurant in DuQuoin. [Petitioner] informed us as he was carrying a packet of the same size sheet rock referenced above in to the restaurant with another person. That other person adjusted his hands which twisted the sheet rock and placed greater weight on [Petitioner.] [Petitioner] stated he felt pain in his low back following this incident. (PX 2, Resp. Ex. 1, pp. 1-2)

Dr. Vaught was provided with a brief summary of Petitioner's treatment beginning on January 13, 2011 and advised of Petitioner's history of intermittent chiropractic care for his low back. Records pertaining to all of the foregoing were included. The doctor was further advised that "[b]ased on [Petitioner's] medical history as well as his expected testimony [Petitioner's attorneys] believed [his] low back and leg symptoms as first documented on January 13, 2011 in the records from Wittenauer Chiropractic were caused or aggravated by the incidents at work where [Petitioner] was lifting drywall in the weeks prior to January 13, 2011." (PX 2, Resp. Ex. 1, p. 3)

Petitioner was examined by neurosurgeon Dr. Vaught, Regional Brain & Spine, in Cape Girardeau, Missouri on April 6, 2015.

A written report of the visit followed on/about May 1, 2015. (PX1) In a letter dated May 1, 2015, FNP-BC Debra Alexander (associated with Regional Brain & Spine) issued a cover note regarding the request for an opinion letter on Petitioner. A summary of the consultation note was included. It was noted that Petitioner sought social security disability because he couldn't return to his heavy physical demand labor. Petitioner also denied the need for evaluation or treatment of any lower back symptoms at the time of the exam. Ms. Alexander further noted "My opinions are within a reasonable degree of medical certainty." (PX 1, p. 10)

The consultation note stated that Petitioner gave a history of an onset of symptoms following "two separate work injuries occurring on or about December of 2010 or January of 2011." (PX1 at 1) Both injuries involved carrying sheet rock. Dr. Vaught noted that the first incident involved carrying returned sheet rock out of an individual's home. (PX 1 at 1)

Petitioner described his initial symptoms following his two work accidents as stinging, burning and aching in his lower back, which progressively worsened. (PX1 at 1) He had not worked since January 10, 2011 due to his symptoms. He was treated operatively by Dr. Hayward, and his overall condition improved following lumbar surgery. Dr. Vaught was under the impression Petitioner was unable to return to his heavy physical demand occupation due to work restrictions that had been recommended by Dr. Hayward. (PX 1 at 1)

Dr. Vaught noted Petitioner's subjective complaints on April 6, 2015 included stinging, burning, and aching, which Petitioner modified with his activities. (PX1 at 1) He denied any post-operative complications, and stated he was pleased with his care both before and after surgery. His pain was rated as 1 out of 10.

Dr. Vaught documented normal motor, sensory, and reflex exams. (PX1 at 3) Range of motion of the lumbar spine was full, and straight leg raise tests were negative. (PX1 at 4)

Dr. Vaught reviewed Petitioner's February 8, 2011 lumbar MRI and stated it showed degenerative disc disease at L2-3 with a small central disc bulge and mild right foraminal narrowing; degenerative disc disease at L3-4 with a broad based disc bulge and a right herniated disc with moderate bilateral foraminal narrowing; degenerative disc disease at L4-5 with a broad based disc bulge and Grade 1 spondylolisthesis and moderate foraminal narrowing; and

degenerative disc disease with moderate foraminal narrowing at L5-S1.The worst foraminal narrowing was on the right at L4-5 and on the left at L5-S1. (PX1 at 4)

Dr. Vaught also reviewed Petitioner's myelogram and post-CT myelogram from May 18, 2011 and Petitioner's lumbar CT scan from November 14, 2011. The May 18, 2011 post-CT myelogram showed a right herniated disc at L2-3, a broad-based disc bulge at L3-4, Grade 1 degenerative spondylolisthesis at L4-5, and a herniated disc at L5-S1 with moderate to severe foraminal stenosis. (PX1 at 5)

Dr. Vaught opined Petitioner's low back and lower extremity symptoms were caused by Petitioner's work accidents. He reasoned that prior to his accidents, Petitioner was not seeking medical care for any active low back or leg problem and Petitioner's mechanism of injury was consistent with the pathology Dr. Vaught observed on Petitioner's diagnostic scans, and was consisted with Petitioner's pre-operative symptoms. (PX1 at 5-6) He felt, certainly, the lifting incidents described by Petitioner aggravated the pathology Dr. Vaught observed on Petitioner's imaging studies. (PX1 at 5). He related the need for Petitioner's treatment, including his lumbar surgery, to his work accidents. (PX1 at 8)

Dr. Vaught believed Petitioner was at maximum medical improvement (MMI) as it related to his work accidents. He placed a permanent 50 pound lifting restriction on Petitioner, with no repetitive bending, twisting or lifting, and no overhead work. (PX1 at 6)

Dr. Vaught was deposed on June 28, 2015. He is a board-certified neurosurgeon and independent medical examiner. (RX2 at 6) Dr. Vaught testified that he examined Petitioner on April 6, 2015 and reviewed his medical records around that same time. He prepared and signed a report containing his findings and conclusions. (RX2 at 7, see also RX1)

Dr. Vaught testified that Petitioner related two separate work accidents occurring in December of 2010 and early in January of 2011. Both involved carrying sheet rock. He testified that the first incident was while Petitioner was carrying sheet rock out of an individual's home and the second incident occurred while Petitioner was taking sheet rock off a forklift at a customer's home. (PX2 at 8) Following the incidents, Petitioner began developing stinging, burning, and aching in his low back, which progressively worsened. These symptoms never resolved on their own. (PX 2 at 9)

Dr. Vaught also testified that Petitioner told him he had experienced intermittent back problems prior to his work accidents. He had previously seen a chiropractor intermittently, but had not recently seen anyone for any actual problems prior to the two 2010 work accidents. (PX2 at 9) Dr. Vaught testified there was no record of any treatment or complaints of either low back or lower extremity pain after March 30, 2010. (PX2 at 23)

Dr. Vaught reviewed the January 13, 2011 note from Wittenauer Chiropractic. (PX2 at 10) Dr. Vaught also testified that the chiropractor noted an onset date of December 30, 2010. Dr. Vaught testified that such a history was consistent with the history provided to him by Petitioner. Petitioner's subjective complaints documented in that note were right sacroiliac articulation and right sciatica, both rated at 10 out of 10. (PX2 at 10) This was described as a new problem.

((PX2 at 10) The documented date of onset in the note was December 30, 2010, which was consistent with the timeframe given by Petitioner on April 6, 2015. (PX2 at 11)

Dr. Vaught also reviewed the March 30, 2010 note from Wittenauer Chiropractic, which was several months prior to the January 13, 2011 visit. (PX2 at 11-12) On that date, Petitioner described left, not right, sacroiliac articulation, and left, not right, lower back pain, and left neck pain. (PX2 at 12) He rated his pain at only 6 out of 10 on that date. (PX2 at 12)

Dr. Vaught further testified concerning his review of Petitioner's medical records from before the 2010 work accidents. (PX2 at 13, 22) According to him, none of those records documented either the type or the severity of the symptoms described in Petitioner's January 13, 2011 record from Wittenauer Chiropractic. (PX2 at 13) Dr. Vaught testified that Dr. Hayward's notation that Petitioner's symptoms began in January of 2011 was consistent with what Petitioner told him. (PX 2 at 16-17) He also testified that Petitioner did not relate to him waking up one morning with back pain (as referenced in the history given at SI Pain Management). (PX 2 at 18) Dr. Vaught felt that none of Petitioner's records from any other provider documented the same severity or type of symptoms as were documented on January 13, 2011. (PX2 at 22)

Dr. Vaught also reviewed Dr. Cochran's January 26, 2011 note. (PX2 at 13) Petitioner's visit was a little more than a week following Petitioner's visit to Wittenauer Chiropractic. (PX2 at 13) Dr. Cochran's note documented severe low back pain and right lower extremity pain for several weeks, which Petitioner first noticed after lifting drywall. (PX2 at 14-15) Dr. Vaught testified this history was consistent with the history given to him by Petitioner on April 6, 2015. (PX2 at 15)

Dr. Vaught reviewed Petitioner's February 8, 2011 lumbar MRI and testified his biggest issue was an L3-4 disc herniation on the right. (PX2 at 15) He also had Grade 1 spondylolisthesis at L4-5, and significant foraminal narrowing at L2-3, L3-4, L4-5, and L5-S1. (PX2 at 15) Dr. Vaught testified that this pathology was consistent with Petitioner's subjective complaints of pain discussed in the January 13, 2011 record from Wittenauer Chiropractic, and Dr. Cochran's chiropractic records. (PX2 at 15)

Dr. Vaught also testified that the pathology he observed on the lumbar MRI was also consistent with the objective physical findings documented by Dr. Cochran on January 26, 2011. (PX2 at 15) Dr. Cochran suspected a radicular problem, which based on the exam and history and MRI, showed findings correlating anatomically to the distribution Dr. Cochran suspected. (PX2 at 15-16)

Dr. Vaught testified that Dr. Hayward's initial treatment record documented Petitioner's symptoms beginning in January of 2011. (PX2 at 16) He felt this was consistent with the timeframe given to Dr. Vaught by Petitioner and Dr. Hayward's documented subjective complaints and objective physical findings were consistent with the pathology observed on the MRI. (PX2 at 16 - 17)

Dr. Vaught also reviewed the records from Southern Illinois Pain Management. (PX2 at 17) The March 2, 2011 note documented complaints of pain, numbness, and aching, as well as

right foot burning, aching, and numbness. (PX2 at 17-18) The note documented Petitioner describing his job duties for Respondent as quite a physical job. (PX2 at 18) Dr. Vaught testified the history of Petitioner's onset of symptoms contained in this note was consistent with what Petitioner told about the two acute events. (PX2 at 18)

According to Dr. Vaught, Petitioner underwent an L4-5 and L5-S1 transforaminal lumbar interbody fusion with instrumentation, then a right L3-4 microdiscectomy and medial facetectomy and foraminotomy, and a right L2-3 laminectomy and foraminotomy. (PX2 at 21) Petitioner did well following surgery. (PX2 at 21)

Dr. Vaught personally met with Petitioner and his wife on April 6, 2015. (PX2 at 25) He took a history from Petitioner and performed a physical exam. His opinions are his own. (PX2 at 25) Dr. Vaught's nurse practitioner, Debra Alexander, assisted with the examination and preparation of Dr. Vaught's report. (PX2 at 24) Dr. Vaught personally reviewed the medical records, and Ms. Alexander acted as a scribe. (PX2 at 24) She translated the handwritten patient form completed by Petitioner[5] into the electronic format, and assisted with obtaining the history from Petitioner. (PX2 at 24) Dr. Vaught routinely has Ms. Alexander assist in the transcription of reports; however, Dr. Vaught reviews all the reports prior to signing. (PX2 at 25)

Dr. Vaught testified that he felt Petitioner was at maximum medical improvement (MMI) and that he needed a permanent 50 pound lifting restriction, as well as restrictions on bending, twisting, and squatting. (PX2 at 25-26) Dr. Vaught causally related the need for these restrictions to Petitioner's work accidents. (PX2 at 28-29)

Dr. Vaught causally related Petitioner's low back and lower extremity symptoms to the two sheet rock lifting incidents Petitioner reported to him. (PX2 at 26) Dr. Vaught testified the disc herniation at L3-4 on the right "was a direct result of that work-related injury." (PX 2 at 27) 27) The degenerative changes were also aggravated, particularly the foraminal stenosis and spondylolisthesis. (PX2 at 27)

Dr. Vaught testified it was significant that Petitioner was not seeking medical care for an active low back or leg problem prior to his work accidents. (PX2 at 27) He also based his opinions on simply talking to Petitioner and hearing him relay the same history. (PX2 at 27) Further, Dr. Vaught based his opinions on the difference in the severity of Petitioner's pain prior to his work accidents and after. (PX2 at 27) The following exchange then occurred:

> Q. The mechanism of injury that [Petitioner] reported to you, was that consistent with causing or aggravating [his] pathology you previously testified to?
>
> A. Yes. Heaving lifting is one of – one of the causes of a herniated disc and aggravating back pain. He also testified that the mechanism of injury, lifting sheet rock, was consistent with a disc herniation and aggravation of preexisting degenerative lumbar conditions.

[5] Not a part of the record.

Dr. Vaught further testified that Petitioner's treatment, including surgery, was reasonable and necessary to relieve Petitioner of the symptoms the doctor believed were causally related to his work accidents and subsequent treatment. (PX2 at 28)

On cross-examination Dr. Vaught acknowledged that the majority of the records he reviewed were from December of 2010 and onward. He further testified that the records he reviewed pre-dating December of 2010 did not describe a severe radicular pain syndrome consistent with a herniated disc. (PX 2 at 30) Dr. Vaught described Petitioner's pre-December of 2010 complaints of intermittent back pain and sacroiliac joint discomfort as transient in nature. Dr. Vaught further testified that he was not provided with any indication of work accidents prior to December of 2010. Furthermore, he did not recall that the medical records he reviewed related or indicated any work accidents prior to December of 2010. (PX 2 at 31)

Dr. Vaught confirmed on further cross-examination that his causation opinions were related to alleged accidents in either December of 2010 or January of 2011. (PX 2 at 31)

On additional cross-examination Dr. Vaught acknowledged receiving a letter from Petitioner's attorney along with medical records to review. That letter was marked as RX 1 to the deposition. Dr. Vaught acknowledged that the history provided to him regarding Petitioner was contained in that letter and was the same history Petitioner provided to him. (PX 2 at 33-34)

Dr. Vaught agreed that there was no mention in Dr. Wittenauer's January 13, 2011 note of any incident wherein Petitioner's back was hurting after lifting drywall. (PX 2 at 34, 35) He agreed that Dr. Wittenauer's notes reference an onset date of December 30, 2010. (PX 2 at 35) Dr. Vaught also agreed that the doctor's notes from that visit state that nothing in particular aggravated Petitioner's problems because they were always there. (PX 2 at 36) Dr. Vaught agreed there was nothing in Dr. Wittenauer's January 1, 2011 note stating Petitioner hurt his back after lifting drywall. He also agreed that Dr. Hayward's record of February 23, 2011 states Petitioner's low back and right hip pain began in January of 2011. He agreed there was no mention in that office visit of an incident involving the lifting of drywall in December of 2010 or January of 2011. Dr. Vaught also agreed that the SI Pain Management record of March 2, 2011 contains a history wherein Petitioner indicated his back pain began when he woke up on January 12, 2011 and that there was no new injury or trauma. (PX 2 at 36-37)

Dr. Vaught testified that chronic pain is defined as pain in the same distribution or location that occurs for more than six months. He agreed that the DuQuoin Chiropractic records from 2007 indicate Petitioner was getting consistent treatment for severe low back pain for several months. He agreed that the April 6, 2007 entry, while hard to read, suggests Petitioner was having some pain after doing extensive lifting and that on May 25, 2007 he had back pain after moving shingles and sheetrock. He also agreed there are references to heavy lifting and back pain on July 16th and July 27th. Dr. Vaught also agreed that the September 23, 2008 entry states Petitioner was having low back pain that started three weeks earlier on the left after moving two by eights at work and that it dissipated slowly after two to three days but about two week earlier he began having pain on the right side with radiation to the front side of his leg to

the knee. He also agreed that on September 25, 2008 the doctor noted Petitioner's low back was still painful and radiating down around the right leg. He agreed that those records indicated Petitioner had experienced low back pain prior to December of 2010. (PX 2 at 37 -41) Dr. Vaught testified that it appeared Petitioner went to the chiropractor 36 times between February and September of 2007 which he would define as "intermittent" and not constant. (PX 2 at 42)

Dr. Vaught further testified on cross-examination that while Petitioner had low back pain during 2007 he was primarily diagnosed with SI joint dysfunction which is back pain but not mechanical low back pain or radicular pain. (PX 2 at 44) He also acknowledged that the doctor's notes from that time refer to low back pain ("lbp"). When asked how the doctor came up with Petitioner's diagnosis of SI joint dysfunction during that period he testified that he was not the doctor then and did not diagnosis Petitioner with it. (PX 2, p. 46)

Dr. Vaught was asked about the dates of injury provided to him. He testified that he did not have a date for the December injury. It was his understanding that the January date was around January 10th. (PX 2 at 47) He further testified that he knew Petitioner last worked on January 10, 2011. When asked if Petitioner ever gave him a specific date of accident, the doctor replied, "I do not have a specific date. He recalls two specific incidents, which are documented here, but I don't have the specific date." (PX 2, p. 48)

Dr. Vaught was asked about a date of injury "3/1/11" as stated on page one of his report. He testified that it was an error as he didn't know where that date came from. When asked if he had received copies of Petitioner's Applications for Adjustment of Claim (one of which referenced a March 1, 2011 accident) Dr. Vaught replied that he had not. (PX 2, p. 49)

Dr. Vaught reiterated that his causation opinion was based entirely upon the history provided by Petitioner at the time of the examination. He also reiterated that such history was the same one contained in the letter from Petitioner's attorney. (PX 2, p. 50)

Dr. Vaught testified that he performed the focal neurologic examination regarding Petitioner's back and legs and Ms. Alexander did a complete neurological examination. He further testified that there is a "glitch" in his office system which is why it appears the letter to Petitioner's attorney was signed by Ms. Alexander. He reiterated that he performed the examination and not Ms. Alexander. Ms. Alexander assisted him in the preparation of the report; however, he reviewed the report. (PX 2 p. 50 – 58)

On redirect examination Dr. Vaught discussed the histories Petitioner provided to his various treating physicians and chiropractors. (PX2 at 69) He further testified that nothing asked of him on cross-examination would change any of his opinions. (PX 2, 61)

On further cross-examination the following exchange occurred:

> Q. …do you have an opinion within a reasonable degree of medical certainty as to whether or not that gap of almost two years [October of 2008 to October of 2010 or January of 2011] is an indication that the problems that

> he sought treatment for in 2007/2008 is not related to the treatment he subsequently had after December, 2010?
>
> A. It was my opinion that the problems that he sought treatment for after December, 2010 was quantitatively different and consistent with a herniated disc. (PX 2 at 65)

On further cross-examination Dr. Vaught was asked about Dr. Wittenauer's note of January 13, 2011. Based upon what was contained in that note, Dr. Vaught was of the opinion Petitioner, on that date, had a herniated disc causing right sciatica; however, he could not testify to a reasonable degree of medical certainty what specific incident caused that pain. (PX 2 at 66) He also testified that he could not state what specific incident was the cause of Petitioner's complaints at the January 14th visit with Dr. Hayward. (PX 2 at 66-67)

On further redirect examination Dr. Vaught was asked if he ever spoke with Petitioner about the histories he gave to the various providers when they met on April 6, 2015. Dr. Vaught testified that Petitioner told him his main priority when he was first seeking care was to get his pain addressed because it was severe and unlike anything he had experienced previously. (PX2 at 69) Petitioner told Dr. Vaught he used his private insurance and he didn't have work comp coverage. (PX2 at 69) Petitioner told Dr. Vaught he was not setting up any sort of workers' compensation claim, he was merely focusing on his pain. (PX2 at 70)

Report and Deposition of Dr. Crane

After Dr. Vaught's deposition and on/about September 18, 2015 Dr. Benjamin Crane performed a records review for Respondent and issued a report thereafter. In a one-page, undated letter addressed to Respondent's attorney, Kelly Phelps, Dr. Crane stated he reviewed the records provided to him concerning Petitioner. Dr. Crane stated:

> [Petitioner] has been under the care of a chiropractor for quite some time but ultimately ended up under the care of Dr. Vaught when he underwent what sounds like a single level TLIF at the L4-5 level for back pain and possibly leg pain. In reviewing the medical record, I do not see any reference to a specific injury at work, with the exception of the Independent Medical Evaluation and ultimate surgery performed by Dr. Vaught. The chiropractic notes failed to state any significant work-related injury for any of his visits dating all the way back to 2007. (RX 2, dep. ex. B)

Dr. Crane was unable to causally relate Petitioner's low back condition to any specific work accident based upon the history contained in the medical record nor could he causally relate the necessity for Petitioner's surgery in June of 2011 to any specific work accident based on the histories contained in the medical records. (RX 2, dep. ex. B)

Dr. Crane was deposed on October 28, 2015. Dr. Crane testified that he is an orthopedic spine surgeon who was board certified in 2010. (RX2 at 5-6) He testified he performed a medical records review at Respondent's attorney's request. (RX2 at 6) He testified he reviewed records from one of Petitioner's chiropractors, the record from Dr. Vaught, and "some of the care by Dr. Hayward." (RX2 at 6)

Dr. Crane admitted he was at a disadvantage in this case because he did not take a history directly from Petitioner. (RX2 at 36-37) He testified that obtaining a history from a patient is almost the most important thing he does when he meets a patient. (RX2 at 8) Dr. Crane likes to know exactly how the patient hurt themselves, and what situation they were in. (RX2 at 8)

Dr. Crane testified that he could not casually relate Petitioner's symptoms and subsequent surgery in 2011 to his claimed work accident based on his review of Petitioner's records, which he testified contained no indication of a work injury that would necessitate Petitioner's back pain. (RX2 at 7)

Dr. Crane testified his report did not identify any specific records that he may or may not have reviewed, other than Dr. Vaught's report. (RX2 at 14-15) He also testified his report referenced a single, unidentified chiropractor. (RX2 at 15) He conceded that a person reading his report would know only that he read a report from Dr. Vaught and from an unidentified chiropractor. (RX2 at 15)

Dr. Crane also testified that his report stated Petitioner had been under the care of a chiropractor "for quite some time." (RX2 at 16) He explained that this referred to Petitioner's chiropractic treatment by Dr. Eaton at Du Quoin Chiropractic Center. (RX2 at 16) Dr. Crane conceded, however, that these records indicated Petitioner was seen for a few months in 2007, followed by a year-long gap. (RX2 at 17). The records also showed chiropractic care in September and October of 2008, followed by a gap of one year and five months. (RX2 at 16)

Dr. Crane also testified that following the one year and five month gap, Petitioner's records then indicated chiropractic visits in March of 2010. (RX2 at 17-18) He noted that the record from Wittenauer Clinic dated March 30, 2010 documented left sacroiliac articulation and left lower back pain, rated at 6 out of 10. (RX2 at 19)

Dr. Crane agreed there was not another record of treatment with Dr. Wittenauer following the March 30, 2010 visit, and further conceded there was no record of any treatment whatsoever for any condition following March 30, 2010, until after December of 2010. (RX2 at 19-20)

Dr. Crane testified that his Petitioner's chiropractic records from March of 2010 documented left-sided symptoms Petitioner rated at 6 out of 10, but his chiropractic records from January of 2011 documented right-sided symptoms he rated at 10 out of 10. (RX2 at 25-26)

Dr. Crane also testified that his reference to workers' compensation claims came not from Petitioner's medical records, but from Respondent's attorney's letter to Dr. Crane. (RX2 at 15-16)

Dr. Crane testified that he recognized the day before his deposition that he misidentified Petitioner's surgeon in his report. (RX2 at 7) He admitted his report stated Petitioner underwent "what sounds like a single level TLIF at the L4-5 level." (RX2 at 20) He testified he reviewed Dr. Hayward's operative report. (RX2 at 20-21) He conceded Dr. Hayward documented not a one-level lumbar surgery, but a four-level lumbar surgery. (RX2 at 22) He testified his own report was inaccurate. (RX2 at 22)

Dr. Crane testified he reviewed Dr. Vaught's record, which contained histories of two specific instances of Petitioner lifting and carrying sheetrock and materials as part of his employment. (RX2 at 23-24) Dr. Vaught's record also stated Petitioner reported he had not returned to work for Respondent since January 10, 2011 because of his symptoms. (RX2 at 24)

Dr. Crane admitted the history of Petitioner's symptoms documented in Dr. Wittenauer's January 13, 2011 note was consistent with the histories of accident documented in Dr. Vaught's report. (RX2 at 26-27)

Dr. Crane admitted Dr. Cochran's note of January 26, 2011 contained a history of severe low back pain radiating into Petitioner's right lower extremity for several weeks. (RX2 at 27). This was also consistent with the histories of accident documented by Dr. Vaught. (RX2 at 27-28).

Dr. Crane testified the January 26, 2011 note from Dr. Cochran documented a history of first noticing symptoms after lifting drywall. (RX2 at 28) Dr. Crane agreed that this reported mechanism of injury was consistent with the histories contained in Dr. Vaught's record. (RX2 at 28)

When asked whether Dr. Cochran's note from January 26, 2011 that Petitioner's symptoms began after lifting drywall was inconsistent with the statement in his report that there was no reference to an injury at work, Dr. Crane was equivocal. (RX2 at 28-29) He testified that while there was a distinct possibility he was referring to a work accident, the record did not specify a date. (RX2 at 29)

Dr. Crane conceded the mechanism of injury documented by Dr. Cochran on January 26, 2011 was documented a few weeks following Petitioner's alleged work accidents. (RX2 at 30) He further conceded that Petitioner's symptoms continued after December 2010 with no gaps in treatment until he had surgery. (RX 2 at 30) This was consistent with the histories documented by Dr. Vaught. (RX 2 at 30)

Dr. Crane admitted Petitioner always had gaps in his chiropractic care of months or even years prior to his alleged work accident, but there were no gaps following his initial visit to Dr. Wittenaeur on January 13, 2011. (RX2 at 31)

Dr. Crane admitted that if the histories of accident contained in Dr. Vaught's record were correct, then those accidents could have caused Petitioner's back and leg pain. (RX2 at 34) Dr. Crane testified that, to a reasonable degree of medical certainty, if Petitioner suffered the two

work accidents he described to Dr. Vaught in December of 2010, those accidents might or could have caused or aggravated Petitioner's low back condition. (RX2 at 34-35) The mechanism of injury as documented by Dr. Vaught could have caused or aggravated Petitioner's low back condition. (RX2 at 35)

Dr. Crane testified he was not offering any opinion as to the reasonableness and necessity of any of Petitioner's treatment, only that the treatment was not causally related to Petitioner's claimed work accidents. (RX2 at 35-36)

Dr. Crane testified he has been performing independent medical examinations or records reviews on behalf of insurance companies and defense attorneys since he came to St. Louis in 2008. (RX2 at 10-11) Approximately 5 to 10 percent of Dr. Crane's practice is dedicated to IMEs. (RX2 at 11) He testified the legal work he performs is split between plaintiffs and defendants. (RX2 at 12)

The Arbitration Hearing

Petitioner's cases proceeded to arbitration on June 13, 2017. At the time of arbitration Petitioner voluntarily dismissed the following claims: 12 WC 33621; 12 WC 33656; 13 WC 10922; and 13 WC 10928. Respondent was represented by Attorney Phelps in case number 12 WC 26843 and 13 WC 10931. Attorney Hoffman represented Respondent in case number 12 WC 26857 and 13 WC 10760.

At the beginning of the hearing Petitioner moved to amend the date of accident in 12 WC 26843 to December 3, 2010, which was granted. Petitioner also moved to amend the date of accident in 12 WC 26857 to February 23, 2007 which was granted and to amend the date of accident in case 13 WC 10931 to December 23, 2010 which was granted.

With regard to case # 12 WC 26843 (D/A – 12/3/10) the disputed issues were: accident; notice; medical bills; temporary total disability benefits; and nature and extent. (AX 1)

With regard to case # 12 WC 26857 (D/A – 2/23/07) the disputed issues were: accident; notice; causal connection; and nature and extent. (AX 3)

With regard to case # 13 WC 10931 (D/A – 12/23/10) the disputed issues were: accident; notice; causal connection; medical bills; temporary total disability benefits; and nature and extent. (AX 7)

With regard to case # 13 WC 10760 (D/A – 9/2/08) the disputed issues were: accident; notice; causal connection; and nature and extent. (AX 5)

Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he is married and his highest level of education was twelfth grade. Petitioner worked for Respondent approximately sixteen years. He last worked for Respondent on January 12, 2011.

Petitioner testified that he worked for Respondent as a delivery handler. In that position he filled customer orders, consisting of shingles, sheet rock, lumber, windows, doors, concrete, concrete blocks, and any other building materials. Petitioner would get an order off the board, pick up the materials, and deliver them to customers. Petitioner further testified that the shingles he handled and delivered came in packages weighing between 75 and 95 pounds per bundle. Additionally, the sheet rock Petitioner handled and delivered weight approximately 100 to 275 pounds per package, depending on the width of the sheet rock. Petitioner testified that sheet rock was 5/8 inches and 12 feet long and weighed approximately 275 pounds.

Prior to the instant claims, Petitioner had never filed a workers' compensation claim.

Petitioner testified that he sustained a work accident in "February of 2007." He explained that he was pulling material out of a bin to load it on the truck and he heard "something" in his back. He thought it was 2 X 8s, 2 X 10s, or 2 X 12s. When asked what part of his body was affected, Petitioner replied that he didn't know for sure but he "knew" it was the lower part of his back. He rated his pain as a "6/10." He went to Bruce Zoller as he "couldn't do it any longer" and Bruce told him to take it easy and see how he did. Petitioner testified that it kept getting worse and he told Bruce he needed to go to the chiropractor and Bruce told him to go. Petitioner also testified that he received some chiropractic treatment from Dr. Eaton and had to start paying for them. He then approached Bruce and told him that wasn't right because it should be workers' compensation since he was hurt pulling materials out of the bin for him. According to Petitioner, Bruce told him that since he paid his health insurance he wanted to keep it off workers' compensation. Petitioner testified that Bruce and Clarence Zoller own the lumber company. Bruce was his boss. According to Petitioner, Bruce Zoller told him he would speak to Dr. Eaton and that Petitioner should keep treating with him. Petitioner testified that he would have filed a workers' compensation claim if Mr. Zoller hadn't told him otherwise.

Petitioner also testified that Dr. Eaton never recommended an MRI or CT scan following the 2007 accident nor was he referred to a surgeon. Petitioner didn't miss any work after the 2007 incident. He would just take it easy when necessary and then return to his regular duties after he felt his strength returning. After some treatment with Dr. Eaton, Petitioner was able to return to full duty work with no restrictions.

Petitioner further testified that he did not undergo any treatment for his low back between October 31, 2007 and September of 2008. He then sustained another accident while lifting shingles and putting them on the laddervator to deliver to some homeowners. As he was getting down to the bottom of a pallet of shingles, he twisted and felt "something" hurt along with pain in the left side of his lower back. He then returned to see Dr. Eaton, the chiropractor. During this time, Dr. Eaton never recommended an MRI or CT scan nor was he referred to a surgeon. He rated his pain as a "5/10."

Petitioner testified that he told the secretary, Beverly Wisely, and Bruce Zoller about this accident. Mr. Zoller, according to Petitioner, told him he would speak to the doctor and once he was better the company would pay the doctor. He didn't file a workers' compensation claim on this accident for the same reason as the earlier one. Petitioner didn't miss any time from work because he just reported to work and took it easy when needed. He eventually returned to full duty work without any restrictions.

Petitioner further testified that he didn't undergo any further treatment after the 2008 incident until March of 2010 when he returned to Dr. Eaton; however, he didn't feel any of that treatment was due to a work accident. He also recalled seeing Dr. Wittenauer on March 30, 2010 but thought it was for his shoulder and upper back. When asked if he would disagree with the records if they reflected left-sided sciatic pain, Petitioner replied "No." Petitioner continued working full duty for Respondent during this time and up through December of 2010.

Petitioner testified that on December 3, 2010 he delivered an order to Alongi's Restaurant in Du Quoin, Illinois, consisting of 11 sheets of 4 X 12 5/8 in. sheet rock and 2 x 4s for an addition to the restaurant. He reviewed a work order for this delivery dated December 3, 2010 confirming this delivery. (PX10) Petitioner testified he did not have access to this work order after he was no longer employed by Respondent, and he also did not have access to that work order at the time he filed any of his Applications for Adjustment of Claim. It was not until PX 10, and other, work slips were provided to his attorney that Petitioner had access to this work slip. Petitioner testified that once he reviewed PX 10 and other work tickets, he was able to pinpoint the date of a work-related injury he sustained, which was December 3, 2010.

Petitioner testified that the packets of sheet rock he deliverd to Alongi's weighed approximately 275 pounds per packet. He, an Alongi's employee, and another gentleman were helping Petitioner. Petitioner explained that he had one end of the packet of sheet rock and the employee had it on the other end, but the packet would bow when you picked it up to take it off the forks. When they stood to lift the sheet rock off the fork lift, it jerked, and almost took Petitioner to the ground. Petitioner testified he felt a bad snap in his low back, and felt pain in his low back and right lower extremity following this accident. He rated his pain as 10 out of 10. He also felt a burning and stinging sensation. Petitioner testified that prior to December 3, 2010, he had never experienced symptoms like the ones he experienced after this accident because this time he felt a snap and a burning and stinging sensation. Petitioner testified these symptoms were very different that the ones he had experienced nine months earlier in March of 2010.

Petitioner testified he notified his boss, Bruce Zoller, about this accident. According to Petitioner, Mr. Zoller told him to take it easy and go to the chiropractor. Petitioner testified that he continued to work despite his symptoms, albeit on modified duty. He testified he did not seek immediate treatment, but knew he had vacation coming up between Christmas Day and New Year's Day, and hoped if he took it easy until vacation that his symptoms would improve. He testified his symptoms did not improve.

Petitioner testified that until the Christmas break he continued to work but his symptoms didn't go away. They then recurred on December 23, 2010, when he made a delivery to a customer, Carl Goldman, consisting of 16 4 X 8 by 1/2 in. pieces of sheet rock. After that

incident, his symptoms continued to worsen. Petitioner reviewed another work order for this delivery dated December 23, 2010 confirming this delivery (PX11).

Petitioner testified he did not have access to PX 11 after he was no longer employed by Respondent, and further did not have access to PX 11at the time he filed any of his Applications for Adjustment of Claim. It was not until PX 11, and other, work slips were provided to his attorney that Petitioner had access to this work slip.

Petitioner testified that once he was able to review PX 11and other work tickets, he was able to pinpoint the date of a work-related injury he sustained, which was December 23, 2010. (PX11).

Petitioner testified that on December 23, 2010, he was delivering sheet rock to, and picking up returns from, Mr. Goldman's house. According to Petitioner, Mr. Goldman was constructing a new home, and Petitioner was required to duck low to go out from the doorways. Petitioner was carrying three pieces of sheet rock, weighing approximately 75 pounds each, out of Goldman's house. He ducked low to exit a doorway, and felt his low back pop again in the same place as he felt after the incident at Alongi's.

Petitioner testified he had the same pain, stinging, and burning in his low back and right lower extremity as he did following the incident at Alongi's three weeks prior. He rated his pain following this incident as 10 out of 10.

Petitioner testified he notified Mr. Zoller of this accident and Mr. Zoller told him to take it easy, that vacation was coming up, and perhaps Petitioner would get better while off on vacation.

Petitioner testified it was commonly known that Mr. Zoller would not allow injured workers to receive workers' compensation benefits because he paid for their group health insurance. Petitioner testified it was that way for his 16 years of employment.

Petitioner testified his symptoms did not get better during the holiday; rather, they kept getting worse. He testified he attempted to return to work in January of 2011, and worked for around seven days, during which he just sat around as he could hardly do anything.

Petitioner testified that around January 10, 2011, he got up to go to work and could not even bend over to pull his socks up or his shoes on. He called Mr. Zoller and told him about his condition. According to Petitioner, Mr. Zoller told him to just stay home and see if his condition improved. Petitioner testified that his condition did not improve and he was unable to return to work again.

Petitioner was required to seek treatment for his condition. His pain and stinging in the right side of his back and his right leg was so bad he could hardly stand it. He rated his pain as 10 out of 10 at that time.

Petitioner testified that he first sought treatment at Wittenauer Chiropractic in January of 2011. He was experiencing pain in the right side of his back. He also noticed a stinging sensation and right leg pain. When asked if he happened to tell anyone at Wittenauer Chiropractic about his injury he testified that he thought he did but he couldn't swear to it.

Petitioner testified he also saw Dr. Cochran, another chiropractor, in January of 2011. He started paying him and told the doctor it wasn't right that he was paying for the treatment when it happened at work but his employer wouldn't let him proceed under workers' compensation since it provided him with his health insurance. According to Petitioner, Dr. Cochran got hold of Bruce Zoller and he gave Petitioner his money back. From then on the doctor couldn't do anything for him and he referred him to Dr. Hayward.

Petitioner testified when he first came under the care of Dr. Hayward, he saw Dr. Hayward's physician's assistant. He remembered the PA's name was Chris. He testified he told Chris he hurt his back working for Respondent and that it should be processed as a workers' compensation claim, but because of Mr. Zoller's statements and policy concerning injured workers not being entitled to workers' compensation benefits because Respondent provided group health insurance, Petitioner told Chris he was required to process the treatment under his group health insurance.

Petitioner testified that PA Chris was the last medical provider to whom he gave a history of his two work accidents in December of 2010 because of Mr. Zoller's statements. He saw at least three more PAs prior to seeing Dr. Hayward, but did not mention to them or to Dr. Hayward his December 2010 work accidents because of Mr. Zoller's requirement that Petitioner use his group health insurance.

Petitioner was asked if he told Dr. Hayward or any of the PAs about the work accidents at Alongi's and Mr. Goldman's and he replied "no" because he was in so much pain at that time he could hardly stand.

Petitioner testified he underwent lumbar injections at Southern Illinois Pain Management. He testified he did not give anyone at Southern Illinois Pain Management a history of his accident at Alongi's or at Goldman's house. Petitioner did not recall giving a history of his pain beginning on January 12, 2011. He testified January 10, 2011 was the date he could not get his socks on, and testified that pain was continuing pain from the accidents at Alongi's and at Carl Goldman's house. His pain did not begin in January of 2011; rather, his pain got so severe at that time that he could not put his socks or shoes on.

Petitioner testified he eventually underwent lumbar surgery on June 23, 2011 performed by Dr. Hayward. He testified he did fine following surgery. He testified he is unable to lift over 50 pounds, and can hardly do any stooping because of ongoing pain. He still has pain in the same locations in his low back and right leg and his functions are limited greatly due to this pain. Petitioner is unable to perform his job duties for Respondent.

Petitioner testified his group health insurance at the time was an 80/20 plan, requiring him to pay 20 percent of his charges out of pocket. He testified he paid more than $5,000.00 out-of-pocket for medical treatment in 2011.

Petitioner testified he last saw Dr. Hayward in 2012, and had to pay for that visit himself, as he no longer had group health coverage. This included paying for an x-ray of his lumbar spine. His group health was cancelled as of January 1, 2012. Dr. Hayward wanted to see Petitioner again, and wanted Petitioner to obtain a CT scan or MRI. Petitioner explained he could not afford either of those scans, and Dr. Hayward settled for an x-ray, which was all Petitioner could afford. He has not returned to Dr. Hayward.

Petitioner testified that in 2015 he met with Dr. Kevin Vaught in Cape Girardeau, Missouri. He testified he actually met with Dr. Vaught, not just Dr. Vaught's PA, and that Dr. Vaught actually performed a physical examination on him. Petitioner testified Dr. Vaught placed permanent restrictions on him, and that Respondent never offered to accommodate those restrictions or bring Petitioner back to work. Respondent never offered Petitioner vocational rehabilitation services or any assistance any sort of job search.

Petitioner testified he has never heard of Dr. Benjamin Crane, and that he had never been examined by him.

On cross-examination, Petitioner testified his pain was a "10/10" after he got hurt in early December of 2010. He agreed that he didn't get any treatment but he continued to show up for work. When asked if he actually worked, he replied he did not as he mostly sat around because he could do very little. He denied making any deliveries after December 3rd. He then testified that he started making some deliveries because he guessed the inflammation went down but those deliveries didn't begin until shortly before December 21, 2010. Petitioner then clarified that he didn't think he did for "maybe four to six days." Petitioner was then asked about a delivery of wood boxes to Taylor Brothers on December 21, 2010. He testified he drove the delivery truck to Taylor Brothers, but they unloaded the materials themselves because he was unable to move them.

Petitioner was also asked about a delivery on December 20, 2010 to Dave Kent. He testified Mr. Zoller had the yard boy load the materials on the truck. Petitioner drove the truck to Dave Kent's, and they unloaded the materials.

Petitioner was asked about a delivery on December 16, 2010 to Jackie Davidson. He testified it was the same as the previous question, that Petitioner was able to drive the truck, but was unable to either load or unload the truck.

Petitioner testified he continued to make deliveries, without loading and unloading the truck, until January 10, 2011 when he was unable to return to work due to pain. Prior to January 10, 2011, he would show up every day and would either sit around, and/or sometimes drive the delivery truck, but did not load or unload the truck.

Petitioner reviewed several work orders from December 1, 2010 to January 11, 2011. (RX7). He testified that some of these deliveries were not made by him. The deliveries he made during that period contain his initials at the bottom.

Petitioner confirmed that on December 1, 2010, prior to the Alongi's work accident, he made deliveries to Searby Funeral Home, Heartland Mechanical, and Du Quoin High School. He also confirmed that on December 2, 2010, also prior to the Alongi's work accident, he made deliveries to Terry Marks, Carl Goldman, and to Brad Galli.

Petitioner testified that deliveries following December 3, 2010 were loaded by Respondent's other employees and unloaded by the customers themselves, as he was unable to load or unload the truck due to his work injury of December 3, 2010.

Petitioner testified that his last day of work for Respondent was January 10, 2011. He was then shown a delivery ticket for January 11th and agreed it had his initials on it but he had no explanation. He thought the 10th was a Tuesday morning and the last day he went in to work. He agreed that the work slips show he continued to work and that he drove the truck and forklift making deliveries. He also agreed that he sought no medical treatment in December of 2010.

Petitioner confirmed on cross-examination that the first time he sought medical treatment following his injuries at Alongi's and at Goldman's house was on January 13, 2011 with chiropractor Dr. James Wittenauer. Dr. Wittenauer's note documented that Petitioner's symptoms were worse when he did nothing because they were always there. Petitioner testified this was true after he was injured. He testified he may have failed to mention his December of 2010 work accidents at that visit, but those accidents were the reason he was there. Petitioner testified the notation in Dr. Wittenauer's records of symptoms beginning December 30, 2010 was inaccurate, and that someone must have written it down wrong.

Petitioner agreed that he underwent chiropractic treatment for left-sided low back pain beginning in February of 2007. Despite an entry in Dr. Eaton's September of 2008 records to the contrary, Petitioner did not believe he had prior right-sided low back pain in September of 2008. He was shown Dr. Eaton's record from September 23, 2008, and conceded the record indicated complaints of right low back and right leg pain, but he testified he recalled his pain being on the left side at that time.

Petitioner also agreed that he underwent chiropractic treatment from February of 2007 until September of 2007. He believed during that time he underwent 28 chiropractic treatments. He also agreed that in September and October of 2008 he underwent seven (7) chiropractic treatments.

On further cross-examination, and contrary to his testimony on direct examination, Petitioner indicated that his treatment in March of 2010 was due to a work accident. He did agree that his complaints in March of 2010 were on his right side. He added, however, that his right-sided complaints began in December of 2010. Petitioner then testified that he didn't remember seeing a chiropractor in March of 2010 as he did not see one until 2011.

Petitioner was shown Dr. Eaton's visits from March of 2010. Petitioner testified that he did not see the doctor at that time. He further testified that there is another "Steve Fred" in DuQuoin and "that was not me." He did agree that he saw Dr. Eaton in October of 2008.

Petitioner testified that Dr. Cochran referred him to Dr. Hayward. When asked about Dr. Hayward's note indicating he was referred by Dr. Furry, Petitioner testified Dr. Furry was his family doctor, but that Dr. Cochran had actually referred him.

Petitioner reiterated that his symptoms began after the two incidents at Alongi's and Goldman's house despite the notation in Dr. Hayward's records that his symptoms began in January of 2011. He testified he did not review Dr. Hayward's records prior to arbitration.

Petitioner reiterated on cross-examination that he told Dr. Hayward's PA Christopher Hodges about his two December of 2010 work accidents despite them not being documented in the initial treatment record of February 23, 2011. He further testified that he may have told the doctor it began in January of 2011 but it really started in December of 2010.

Petitioner testified he was seen at Southern Illinois Pain Management on March 2, 2011. He confirmed the note from this visit stated his symptoms began after awakening from sleep on January 12, 2011 with no new injury, but he testified his symptoms began in December despite what was documented in this record. Petitioner testified the Southern Illinois Pain Management record from March 2, 2011 does not accurately describe what had happened to him.

Petitioner denied that his low back condition simply gradually got worse over time while working for Respondent. He testified that "when something hits you like that and takes you almost to your knees, you know that's when it happened." Petitioner testified he was one of the strongest men who ever worked for Respondent, but following the two incidents in December of 2010, he could not perform his duties anymore.

Petitioner agreed there was no incident or accident that occurred in January of 2011. Petitioner testified that on January 10, 2011 his pain got so bad that he could no longer stand it and could no longer even drive. He again related that pain to the two incidents in December of 2010.

Petitioner testified he saw Dr. Hayward for the last time on June 22, 2012 after he had his lumbar x-ray made. Dr. Hayward's note indicated he would most likely release Petitioner from care after a one-year follow up. Petitioner did not follow up in 2013 with Dr. Hayward because he could not afford it, as his group health insurance had been cancelled.

Petitioner testified he saw Dr. Vaught on the advice of his attorney. Dr. Vaught did not render any treatment, but examined him, and advised him to apply ice every 20 minutes. He saw Dr. Vaught once.

Petitioner testified he has not sought work since retiring in 2016, when he turned 66 and began receiving Social Security benefits. Prior to that, he had received social security disability benefits, but was not a Medicare recipient.

Petitioner testified it was not accurate to say his low back pain developed in 2007 and continued until he quit working in January of 2011. He testified his prior low back pain resolved in 2008.

Petitioner testified he first saw chiropractor Dr. Eaton in 2002 for what he believed to be a shoulder issue. He treated with Dr. Eaton beginning in February of 2007 for a low back condition, during which time he continued to show up to work. He lost no time.

Petitioner testified that at the end of his treatment with Dr. Eaton in 2007, he was released to work full duty with no restrictions. He also testified that his back pain was "completely gone" after 2008. He then did not seek any further treatment until January of 2011.

On further cross-examination Petitioner agreed that he saw Dr. Eaton in for several months in 2007 for left-sided back pain. During that time he continued to work or, as he described it "showed up.' He did not lose any time from work. He was released with no restrictions in 2007.

Petitioner further testified that after another incident he returned to Dr. Eaton in September of 2008. Petitioner again treated with Dr. Eaton approximately seven (7) times from September to October, 2008 for left-sided back pain. After those seven visits, Petitioner quit going to Dr. Eaton because he felt good enough to work full duty without restrictions. He returned to his full duty work at that time. He lost no time following the 2008 work accident.

Petitioner further testified that he had no back problems from October of 2008 until his two work accidents in December of 2010 and his symptoms following those work accidents were right-sided.

On redirect examination Petitioner confirmed that he reviewed the work tickets from December 1, 2010 to January 11, 2011. (RX7) He testified that his initials on a work ticket did not mean that he physically loaded and unloaded materials. He was responsible for making sure the materials on the ticket were delivered. After he was injured on December 3, 2010, he testified that even Mr. Zoller told customers they would be required to unload the materials themselves, and Mr. Zoller had other employees load the materials for Petitioner; however, he could still drive at that point.

Petitioner testified that, assuming he underwent chiropractic treatment in March of 2010, approximately nine months prior to December of 2010, he received no other treatment after March of 2010. He saw no chiropractor, physician, surgeon, or any other medical professional from March of 2010 until after his work accidents at Alongi's and Carl Goldman's house.

Petitioner testified he knew for certain he was injured at Alongi's on December 3, 2010, and at Carl Goldman's house on December 23, 2010. He denied simply picking two dates.

Petitioner was shown an Application for Adjustment of Claim with a date of accident of "December 2010." (RX1; see also AX2). Petitioner testified he could not remember the exact

date of this injury until he reviewed the work order tickets. He knew it had been in the month of December.

Petitioner admitted filing other Applications for Adjustment of Claim claiming dates of accident of December 1, 2010, December 7, 2010, January 4, 2011, January 12, 2011, and March 2, 2011. Petitioner testified these were filed before he reviewed the work order tickets.

Petitioner testified that the Application for Adjustment of Claim for Case No. 12-WC-26843, on which the date of accident was amended to December 3, 2010, described an incident lifting sheet rock and roofing shingles to customer Alongi's Restaurant in the regular course of employment. Petitioner testified he had always been able to identify Alongi's Restaurant as the location where he was injured. The work ticket from December 3, 2010 described the same delivery to Alongi's as was described in his Application for Adjustment of Claim. (PX 10)

Petitioner was also shown an Application for Adjustment of Claim with a date of accident December 7, 2010. Petitioner testified that the location of the accident contained in this Application for Adjustment of Claim was Carl Goldman's house. (RX1)

Petitioner testified it was "fair to say" he knew he had been injured at Alongi's and at Goldman's house even prior to reviewing the work tickets. The work order tickets for Alongi's on December 3, 2010, and for Carl Goldman on December 23, 2010, confirmed the actual dates for Petitioner. (PX10; PX11)

Petitioner was asked why he filed so many Applications for Adjustment of Claim if he knew he had been injured at Alongi's and at Goldman's house. Petitioner testified he did not know, and that perhaps it was because his attorney told him to. Regardless, Petitioner testified that once he got the work order tickets, he knew exactly when he had been injured. He always knew where, but the work tickets confirmed when.

The Arbitrator concludes:

Petitioner's Credibility.

At the outset the Arbitrator notes that, initially, Bruce Zoller's absence was troubling given Petitioner's testimony as to comments by him as well as his alleged business practices regarding the handling of work injuries. However, as she reviewed the record and the testimony of Petitioner this became less of a concern as she determined that Petitioner, himself, was not a credible witness and his testimony about Mr. Zoller may have been largely self-serving given the disputed issues of accident and notice in all four of his claims. Furthermore, the take-away from Petitioner's testimony was the suggestion that he didn't want to mention a work accident to any doctors so that his group health would cover the costs per Mr. Zoller's "wishes." However, Petitioner had been working for Respondent for seventeen years. He had mentioned work accident in prior visits (2002 and 2008) and he had told Dr. Sowerby about gradually developing work-related problems.

There were other inconsistencies in, not only Petitioner's testimony on direct examination and cross-examination but between his testimony and what is found in the medical records.

Petitioner testified that he had no right-sided back/leg complaints in September of 2008. Dr. Eaton's records show otherwise. Petitioner acknowledged having some low back treatment in March of 2010 and some right-sided complaints during that time but further claimed they were unrelated to any work accident. He then testified to the contrary on cross-examination as he denied any treatment in March of 2010 whatsoever and further claimed there was another person with the same name as his living in DuQuoin who must have had that treatment; however, no steps were taken to clarify this by affidavit or deposition of the doctor. Furthermore, it seems strange that, if Petitioner didn't treat in March of 2010 as shown by the records, why was Dr. Vaught asked to assume that he did? There was also Dr. Eaton's note of 2011 in which he stated he had last seen Petitioner in March of 2010. Finally, there was Dr. Wittenauer's reference in January of 2011 to having last seen Petitioner in March of 2010. Thus, two of Petitioner's treating doctors acknowledged treating Petitioner in March of 2010 contrary to Petitioner's testimony.

Petitioner presented to Wittenauer Chiropractic on January 13, 2011 with a "new problem" that the doctor attributed to an onset date of December 30, 2010. The doctor also noted that his diagnosis from December 30,2010 needed to be amended. Petitioner, on cross-examination, was asked about the history and testified it was wrong and that someone must have written it down wrong. Petitioner knew accident was in dispute with regard to his claims and, yet, he undertook no effort prior to arbitration to correct a possible scrivener's error or otherwise address what he felt was a mistake. His explanation for the history wasn't persuasive.

A review of Dr. Sowerby's March of 2011 report shows that Petitioner told the doctor he had noticed gradually increasing back pain with the work he had been doing over the years as a delivery person. (RX 6) However, at the hearing Petitioner denied any gradual pain stemming from work duties and he voluntarily dismissed his claims based upon repetitive trauma thereby seeming to contradict any history provided to Dr. Sowerby. Again, another inconsistency.

Another major inconsistency stems from Petitioner's testimony regarding his level of activity at work after the alleged December 3, 2010 accident. Petitioner testified that after his alleged December 3, 2010 accident he was unable to work full duty for Respondent (ie. lift and carry) as his symptoms weren't going away so he worked "modified duty." He testified that he then had another accident on December 23, 2010 while carrying sheet rock out of Carl Goldman's home. On cross-examination Petitioner was asked if he actually worked after December 3rd and he replied that he mostly sat around "because he could do very little." Petitioner also denied making any deliveries after December 3rd but then acknowledged making some deliveries because "he guessed his inflammation had lessened." Petitioner was also asked about a number of delivery tickets bearing his initials. He testified that he only drove the delivery truck and that others loaded and unloaded because he was unable to do so. Petitioner further testified that he only sat around at work or drove the delivery truck and others loaded and unloaded because he was unable to do so. If Petitioner is to be believed regarding his inability to physically do anything for Respondent after December 3, 2010 then his testimony about

sustaining another accident on December 23, 2010 is untrue as, by his own testimony, he couldn't have been carrying anything at Carl Goldman's home. Alternatively, if his testimony about his level of activity was not true then he continued to work full duty making deliveries. Either way, Petitioner's believability has been undermined.

Yet another credibility issue surfaced regarding Petitioner's testimony regarding his referral to Dr. Hayward. Petitioner testified that Dr. Cochran referred him to Dr. Hayward. That is not corroborated by Dr. Cochran's records. Furthermore, Dr. Hayward's records indicate "Dr. Furry" (Petitioner's family doctor – see p. 20 of PX 3) was the referring physician (and Dr. Furry received copies of all office notes from Dr. Hayward). Petitioner provided absolutely no testimony as to why Dr. Furry referred him to Dr. Hayward (since he claimed Dr. Cochran did so). Additionally, Dr. Furry's records aren't a part of the record which is troubling since it is clear from Dr. Hayward's records that the referral to a spine surgeon came from him.

Petitioner went into the arbitration hearing knowing that "accident" was an issue in each of his four cases that were going forward. With regard to the alleged accident dates in December of 2010, it wasn't just the date of accident being disputed but also the mechanisms of injury and lack of any real corroboration for either alleged date of accident in Petitioner's treating medical records. Petitioner testified that on December 3, 2010 he was delivering sheet rock to Alongi's restaurant. He testified that he was injured while lifting street rock and that two other people were working with him when it happened (one of which was an employee of Alongi's). Petitioner could have subpoenaed these people or obtained affidavits from them to corroborate his testimony. He didn't and he provided no explanation as to why he couldn't or didn't.

Similarly, Petitioner testified that he wasn't sure if he told Wittenauer Chiropractic about his December 3, 2010 accident. He also testified that he told Dr. Cochran he injured himself at work and that he told Dr. Hayward's PA-C Chris Hodges about hurting his back at work. None of the records of these treaters corroborates Petitioner's testimony. Again, Petitioner could have deposed them to obtain corroboration; however, he didn't.

Further credibility issues come to light upon reviewing Dr. Vaught's consultation exam. Dr. Vaught's report references that Petitioner told him he was unable to return to work for Respondent due to work restrictions recommended by Dr. Hayward. This is untrue as Dr. Hayward's office notes and records fail to mention any permanent restrictions or recommendations. It also appears that Petitioner never advised Dr. Vaught that he never returned to Dr. Hayward for a final release. Petitioner testified that Dr. Vaught recommended he use ice every twenty minutes. There is no corroboration for that within Dr. Vaught's report or deposition. Petitioner's misrepresentations undermine his credibility.

Lastly, the Arbitrator found Petitioner's testimony about his current abilities difficult to believe and contrary to the objective reports and records in evidence. Petitioner's voiced complaints and limitations at trial essentially mirrored those of the permanent restrictions imposed by Petitioner's examining physician, Dr. Vaught. In comparison is the fact Dr. Hayward, when last seeing Petitioner after his surgery, noted Petitioner was doing "extremely well" with tolerable pain complaints at most. He required no medication. Petitioner was to follow up with Dr. Hayward but didn't. There was a gap of three years between Petitioner's last visit

with Dr. Hayward and his examination with Dr. Vaught. When examined by Dr. Vaught, Petitioner's physical examination was recorded as normal with only subjective complaints being noted. Dr. Vaught provided no reason as to why the permanent restrictions were necessary. He was, based upon Petitioner's history to him, erroneously under the impression Dr. Hayward had recommended permanent restrictions. There was no corroboration by any credible objective evidence for Petitioner's testimony regarding any current limitations and difficulties.

Issue C: Did an accident occur on December 3, 2010 that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner failed to prove that he sustained an accident on December 3, 2010 that arose out of and in the course of his employment with Respondent. This conclusion is based upon Petitioner's general lack of credibility and the lack of corroboration otherwise apparent from the record.

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim, including proof that he suffered an accident which arose out of and in the course of his employment. Nee v. Illinois Workers' Comp. Comm'n, 2015 IL App (1st) 132609WC (1st Dist. 2015). Petitioner failed to meet his burden herein.

First, there is no history of a specific work accident on December 3, 2010 contained in Petitioner's medical treatment records. At the time of arbitration Petitioner amended his date of accident to December 3, 2010. He testified that while making a delivery at Alongi's Restaurant, he felt a pop, and immediate low back and right leg pain, that he rated at 10 out of 10 while making that delivery. Petitioner's medical records contain no mention of such a history – either by date or description. Petitioner did not seek any medical treatment after December 3, 2010 (despite "excruciating pain of a 10/10") until January 13, 2011. At that time he gave an onset date of "December 30, 2010" and he did not provide any details as to what happened on December 30th or where it occurred. There was no mention of a pop or the lifting of drywall while making a delivery to a restaurant.

When Petitioner presented to Dr. Cochran on January 26, 2011 he did not mention an accident in early December of 2010; rather, he referenced low back pain for "several weeks." "Several" suggests more than two and less than many (certainly less that eight weeks or almost two months). While Petitioner mentioned lifting drywall he provided no specific details as to time, place, or date.

Next, Petitioner presented to Dr. Hayward on February 23, 2011 and gave an onset date of "January 2011" with no other details.

When seen by Dr. Sowerby on March 2, 2011 Petitioner gave an onset date of January 12, 2011 when he experienced back pain upon awakening. While Petitioner also described a gradual increase in back pain over the years associated with his work as a delivery person for Respondent. While Petitioner originally had four claims on file alleging a repetitive trauma theory, those four claims were voluntarily dismissed by Petitioner at the beginning of the

arbitration hearing. Thus, it appears Petitioner voluntarily abandoned any repetitive trauma theory for his injuries and, as such, it becomes difficult to believe Petitioner's testimony that the symptoms Petitioner experienced on January 10, 2011 were an escalation of any pain beginning on December 3, 2010. Such a theory is further undermined by the fact that Petitioner alleged yet another accident on December 23, 2010.

In summary, with regard to a specific accident having occurred on December 3, 2010, Petitioner failed to present any credible corroborating history to the four doctors he sought treatment from after the alleged incident. While Petitioner attempted to explain this away by "blaming" Mr. Zoller, Petitioner's testimony regarding that wasn't credible given the over-all problems with his credibility.

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

Even assuming, arguendo, that Petitioner sustained an accident on December 3, 2010, Petitioner failed to prove that his current condition of ill-being is causally related to that injury.

The only medical testimony offered by Petitioner to establish that his low back condition was causally related to his December 3, 2010 injury was that of Dr. Vaught. Dr. Vaught, however, was not a treating physician. Rather, Dr. Vaught was retained by Petitioner's attorney to examine him. Dr. Vaught's causation opinion, however, was not persuasive. A causation opinion is only as good as the history upon which it was based. Dr. Vaught lacked a complete and accurate understanding of Petitioner's medical treatment and Petitioner misrepresented some of his medical history to the doctor (such as being unable to return to work for Respondent per Dr. Hayward's recommendations). His opinion only took into consideration the history Petitioner gave him when they met. (PX 2, p.26). Dr. Vaught's opinion mirrored the information given to him by Petitioner's attorneys and was based upon the history provided to him by Petitioner which, coincidentally, mirrored what was contained in the engagement letter from Petitioner's attorneys. Dr. Vaught was under the erroneous impression that Petitioner's accidents occurred in December of 2010 and January of 2011. He was also under the erroneous impression that Petitioner first injured his back stooping to carry 100# sheets of sheet rock out of a house and was then re-injured carrying a packed of same-sized sheet rock into a restaurant with another person. Petitioner testified to two accidents in December and occurring in the opposite order. He also testified that the sheet rock was being delivered by forklift and that the alleged accident occurred while picking up the packets off the forklift with another person. Contrary to Dr. Vaught's understanding, Petitioner wasn't carrying anything. Dr. Vaught also could not causally relate Petitioner's low back condition to a specific work accident when he considered the various histories contained in the medical records. (PX 2, p.66-68). Dr. Vaught was also unaware that at the time he examined Petitioner, Petitioner was also claiming repetitive trauma injuries to his back. Finally, Dr. Vaught's testimony that the history provided to him by Petitioner regarding his accidents was consistent with what was contained in the various (and differing) histories of other doctors was simply not believable given the totality of the medical treatment records herein.

Petitioner failed to meet his burden of proof that his current condition of ill-being is causally related to his alleged accident of December 3, 2010. Petitioner's claim for compensation is denied.

Issue "E" Was timely notice of accident given to Respondent?

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"—TTD
Issue "L"—What is the nature and extent of the injury?

Given the Arbitrator's determinations regarding accident and causation as set forth herein, the remaining issues ("E", "J", "K", and "L") are rendered moot.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAUL FRED,

Petitioner,

vs.

NO: 12 WC 26857

DUQUOIN HOME LUMBER ,

Respondent.

18IWCC0358

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, and permanent partial disability (PPD), and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

For reasons stated in Decision 13 WC 10931, the Commission finds the Petitioner credible. The Commission otherwise affirms and adopts all else.

IT IS THEREFORE ORDERED BY THE COMMISSION, that the Decision of the Arbitrator filed August 17, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

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

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

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

18IWCC0358

party commencing the 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 – 2018

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 4/16/18
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FRED, PAUL S
Employee/Petitioner

Case# **12WC026857**

12WC026843
13WC010760
13WC010931

DuQUOIN HOME LUMBER
Employer/Respondent

18IWCC0358

On 8/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

0693 FEIRICH MAGER GREEN & RYAN
D BRIAN SMITH
PO BOX 1570
CARBONDALE, IL 62903

1454 THOMAS & ASSOCIATES
ROBERT HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

18IWCC0358

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

Paul S. Fred
Employee/Petitioner

v.

DuQuoin Home Lumber
Employer/Respondent

Case # 12 WC 26857

Consolidated cases: 12 WC 26843, 13 WC 10760, 13 WC 10931

An *Application for Adjustment 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 **June 13, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 23, 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 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 **$21,621.60**; the average weekly wage was **$415.80**.

On the date of accident, Petitioner was **57** 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 **$N/A** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$N/A**.

Respondent is entitled to a general credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on February 23, 2007 that arose out of and in the course of his employment for Respondent, that timely notice of his alleged accident was given, or that his current condition of ill-being is causally connected to his alleged accident of February 23, 2007. 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

August 11, 2017
Date

AUG 17 2017

Paul S. Fred v. Du Quoin Home Lumber, 12-WC-26857

Findings of Fact and Conclusions of Law

Petitioner originally had eight claims pending against Respondent. Four of these claims were dismissed at the time of arbitration. The remaining four cases went to arbitration with the parties understanding that separate decisions would issue for each claim. Petitioner alleges an accident date of February 23, 2007 in this claim.

The Arbitrator finds:

Petitioner's medical records date back to 2002. On December 4, 2002, Petitioner was seen at DuQuoin Chiropractic Center. Petitioner's Patient Information Form references an injury date of December 2, 2002 which was job-related. (PX 4; RX 3) Petitioner was complaining of neck stiffness and headaches. A history of having been bucked off a horse and left shoulder complaints stemming from "extensive overuse of the left arm" was noted. According to the note, "this all happened about a year ago." Dr. Eaton also noted that Petitioner had occasional back pain described as "crampyness [sic]." (PX 4; RX 3)

Petitioner continued to see Dr. Eaton on six occasions in December of 2002 regarding his left shoulder, left index finger, and mid-back. (PX 4; RX 3)

Petitioner returned to see Dr. Eaton on February 26, 2007, having last been seen there in December of 2002. Petitioner was very sore in the L4-S1 levels and was having difficulty walking, with his symptoms in his low back having been steadily getting worse for the preceding 3 – 4 days. Petitioner continued to see Dr. Eaton in February and March of 2007. Dr. Eaton noted Petitioner's need to periodically sit at work every hour or so and then the pain would stop. Petitioner was also noted to be doing housework and riding his horse, although not very fast. On March 28, 2007 Dr. Eaton noted that Petitioner had been very sore the day before after moving some shingles. (PX 4; RX 3)

Petitioner continued to see Dr. Eaton in April and May of 2007. (PX 4; RX 3) On May 11, 2007, Petitioner reported he was steadily improving and had been very active the previous week. On May 18, 2007, Petitioner reported he was continuing to improve, and that he was performing nearly his normal work duties with only a dull ache. On May 25, 2007, Petitioner reported doing his normal work, which included moving shingles and sheetrock, with very little difficulty.

Petitioner was seen by Dr. Eaton three (3) times in June of 2007 reporting only minimal symptoms consisting of a dull ache on June 1, 8, 22, and July 6, 2007. On July 6th Petitioner reported doing very well and working long days with lots of heavy lifting and experiencing only a dull ache rather than any sharp pain. (PX 4 at 6, RX 3)

On July 16, 2007, Petitioner reported to Dr. Eaton that his low back was very painful after performing heavy lifting. (PX4 at 5). He also reported bilateral leg pain on this date.

Petitioner was seen on July 17, 20, and 24, 2007, complaining of a painful low back. On the 20th he associated his pain with lifting his granddaughter. (PX 4; RX 3)

By July 27, 2007, Dr. Eaton noted Petitioner was doing much better. (PX4 at 5). On August 10, 2007, Petitioner reported only occasional dull aching with no sharp pain despite working very hard at work performing lots of lifting. (PX 4; RX 3)

On September 7, 2007, Petitioner returned to see Dr. Eaton reporting that he was doing very well with only occasional dull aching and no sharp pain. (PX 4; RX 3)

Petitioner was not seen again by Dr. Eaton until September 23, 2008, more than a year following his last visit. (PX4 at 5). Dr. Eaton's note described low back pain beginning approximately three weeks earlier on the left after moving 2x8s at work. He stated the pain dissipated two or three days thereafter with the use of ice, but had returned approximately two weeks earlier to the visit, and included right-sided dull pain radiating to the front side of his leg to his knee. (PX 4; RX 3)

Thereafter Petitioner continued his chiropractic treatment with Dr. Eaton with an additional two visits in September of 2008 and four (4) visits in October of 2008. (PX4 at 4-5; RX 3) As of September 29, 2008, Petitioner felt 90 percent better with an occasional sharp pain when "twisting wrong." During the October visits, Petitioner reported only dull aching or intermittent sharp pain following walking and lifting.

Petitioner returned to see Dr. Eaton on March 8, 2010, having last been seen in October of 2008. Dr. Eaton noted Petitioner had very severe lower back pain and left sacroiliac joint pain. He was having difficulty walking but denied any radiating pain. On March 9, 2010 Dr. Eaton noted no significant change in Petitioner's condition. He still had difficulty walking and sleeping. Dr. Eaton wrote, "He has steadily been getting worse for about 3 weeks but no specific injury to cause it." (RX 4)

Records from Wittenauer Chiropractic, located in Pinckneyville, Illinois, indicate that Petitioner was seen one (1) time for chiropractic treatment on March 30, 2010. (PX5 at 4[1]) According to a general information sheet, Petitioner was there due to neck and back pain. He gave an onset date of "three weeks ago." (RX 4) He denied that the condition was getting worse but indicated that it interfered with his work, sleep, and daily routines. In response to the question "Have you had this or similar conditions in the past?" Petitioner marked "Yes" and noted "Just lower back." (RX 4) When seen by the doctor, Petitioner complained of left sacroiliac and left lower back pain, rating both at 6 out of 10. When asked what aggravated his problem, he responded "it is when he bends and lifts too much." Petitioner also reported that his problems became better when he used NSAIDs and rested. (PX 5 at 4) Petitioner was moderately tender over his left sacroiliac articulation. In the prone position, a functionally short right leg length was noted. An onset date of February 28, 2010 was also noted. (RX 4)

[1] See also RX 4, a copy of Wittenaur Chiropractic records.

According to Respondent's delivery records, on December 1, 2010 Petitioner made deliveries to the old Baptist Church, Searby Funeral Home, DQ High School, and Dave Kent. (RX 7)

According to Respondent's delivery records, on December 2, 2010 Petitioner made deliveries to Jackie Davision, Terry Marks, Brad Galli, John Tilley, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 3, 2010 Petitioner made deliveries to Steve Eisenhauer, McPherson Auto, and Terry Marks (Job – Alongi's). (RX 7; PX 10)

According to Respondent's delivery records, on December 4, 2010 Petitioner made deliveries to Doug Hill, Steve Epplin, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 6, 2010 Petitioner made a delivery to Eric W. (RX 7)

According to Respondent's delivery records, on December 7, 2010 Petitioner made deliveries to Carl Goldman and Dave Kent. (RX 7)

According to Respondent's delivery records, on December 8, 2010, Petitioner made deliveries to Kenny Heape and Pete Daumond. (RX 7)

According to Respondent's delivery records, on December 9, 2010 Petitioner made deliveries to Terry Marks, Gary Dickerson, Joel Tolliver, Steve Eisenhauer, P.C.H.A., Gerald Weeks, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 10, 2010 Petitioner made deliveries to Chris Albers, Steve Eisenhauer, Pinckneyville High School, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 13, 2010 Petitioner made a delivery to Tom Denton. (RX 7)

According to Respondent's delivery records, on December 14, 2010 Petitioner made a delivery to Steve Eisenhauer. (RX 7)

According to Respondent's delivery records, on December 15, 2010 Petitioner made deliveries to Carl Goldman and Absolute Construction. (RX 7)

According to Respondent's delivery records, on December 16, 2010 Petitioner made two deliveries to Jackie Davision. (RX 7)

According to Respondent's delivery records, on December 17, 2010 Petitioner made a delivery to Matt Milam, the Elks Club, and Ron Davis. (RX 7)

According to Respondent's delivery records, on December 20, 2010 Petitioner made a delivery to Gene Creek, Chase Porter and Dave Kent. (RX 7)

According to Respondent's delivery records, on December 21, 2010 Petitioner made a delivery to Monte Kuhnert, Carl Goldman, Chase Porter, and Taylor Brothers. (RX 7)

According to Respondent's delivery records, on December 22, 2010 Petitioner made a delivery to "5 - Star." (RX 7)

According to Respondent's delivery records, on December 23, 2010 Petitioner made a delivery to Carl Goldman. (PX 11)

According to Respondent's delivery records, on January 4, 2011 Petitioner made a delivery to Amanda Dearmond, Mark Roznowki, and Graham's Painting. (RX 7)

According to Respondent's delivery records, on January 11, 2011 Petitioner made a delivery to Kellerman's Powder Coat. (RX 7)

On January 13, 2011 Petitioner returned to Wittenauer Chiropractic, having last been seen in March of 2010 and described a "new problem" of right-sided sacroiliac and sciatic pain that he rated at 10 out of 10. Dr. Wittenauer also wrote "The patient's diagnosis from Thursday, December 30, 2010, was amended today." The note also contains a date of onset of December 30, 2010. When asked what made the problem worse, Petitioner responded that "it's worse when he does nothing in particular because it is always there." Petitioner also reported that nothing was relieving his problems. (PX 5; RX 4)

On January 14, 2011, Petitioner returned to Wittenauer Clinic, reporting that he was doing better but also complaining of 9 out of 10 right sacroiliac and right sciatic pain. He underwent chiropractic treatment on that date. Petitioner was advised to return as needed. (PX 5 at 2)

On January 26, 2011, Petitioner was seen by Dr. Douglas Cochran, Tri-County Chiropractic Centre, in Du Quoin, Illinois. (PX3 at 17) Petitioner completed a "New Patient Case History" form. He indicated that his chief complaint was right-sided back pain and pain down his right leg. He claimed his injuries were due to an on-the-job injury but he left the date of accident blank and stated that he didn't intend to turn it in to workers' compensation. (PX 3 at 19) Dr. Cochran noted that Petitioner had been experiencing severe lower back pain and right lower extremity pain for several weeks and had been unable to work for the past two weeks due to his pain. Petitioner stated he first noticed his pain after lifting drywall and that this had happened before but was getting worse. His pain was located in his L3 to S1 region, as well as his right upper anterior thigh. He rated his pain at 8-9 out of 10. Dr. Cochran suspected a lumbar discopathy based upon lumbar x-rays which revealed mild degenerative changes throughout Petitioner's lumbar spine. His physical exam yielded a positive straight leg raise test on the right, positive Lasegue's and Braggard's tests on the right, and right quadriceps weakness. (PX3 at 18) Dr. Cochran assessed Petitioner with lumbar discopathy on this date, which he characterized as a "new condition." (PX3 at 15)

Petitioner returned to Dr. Cochran for four (4) chiropractic treatments in January and February of 2011, before Dr. Cochran referred Petitioner for an MRI of his lumbar spine. (PX3 at 2-14) Petitioner did not return to Dr. Cochran following his MRI. (PX3).

On February 8, 2011, Petitioner underwent a lumbar MRI at Cedar Court Imaging, in Carbondale, Illinois. (PX 3; PX6) The MRI revealed a disc protrusion or mild herniation at L2-3 in the right paracentral region of the spinal canal extending toward the right foramine, resulting in moderate to severe spinal stenosis and right foraminal stenosis. (PX6 at 2) There was asymmetric disc bulging at L3-4 toward the right. At L4-5, there was moderate to prominent left facet arthropathy indenting and compressing the left lateral and left posterolateral aspects of the thecal sac. At L5-S1, there was asymmetric bulging of the disc centrally and posterolaterally toward the left extending into the inferior left foramine. Summarily, Petitioner had evidence of multilevel disc disease with areas of spinal stenosis and foraminal stenosis as noted in the findings.

On February 23, 2011, Petitioner was seen by a physician's assistant at the office of neurosurgeon Dr. Franklin Hayward, Heartland Spine, in Marion, Illinois. (PX9 at 25[2]) Petitioner had been referred by Dr. Furry for his lower back, right hip, and leg pain. According to the note "This started in January 2011." Petitioner had tried conservative treatment but had not experienced any relief. Dr. Hayward's note documented decreased range of motion, paralumbar tenderness, sciatic nerve tenderness on the right, and positive straight leg testing on the right. (PX9 at 25) Dr. Hayward's note also noted decreased sensation in the S1 distribution. Per the MRI, Petitioner was felt to have a disc protrusion asymmetric towards the left along with multilevel disc bulging and degeneration. He noted a disc protrusion at L5-S1 touching the exiting nerve root, and assessed Petitioner with right L5-S1 radiculopathy. He referred Petitioner for an epidural steroid injection.

On March 2, 2011, Petitioner was seen at Southern Illinois Pain Management, Marion, Illinois, by Dr. Julie Sowerby. (PX8 at 8-11; RX 6) Petitioner described his problem as right leg numbness and aching, right foot burning, aching, and numbness and chronic burning and stabbing pain in his lumbar region and right buttock. Petitioner described the aggravating factors as sleep/rest, sitting and walking. In the narrative portion of the report, the doctor stated:

> [Petitioner] has a quite physical job working for a lumber yard. He reports that he has noticed gradually increasing back pain with the work that he does over a number of years. He states that he is a delivery person, and has to lift and move packets of shingles, which are quite heavy. He reports that his back pain began upon awakening from sleep on January 12, 2011. He did not have any new injury or trauma at that time. He does note difficulty performing his job duties due to his low back and leg pain. .....He states that prior to this morning in January when he awakened with pain, he did not have the leg symptoms that he currently has. ... (RX 6)

[2] See also RX 5.

Dr. Sowerby noted Petitioner had difficulty with driving, leisure activities, sleeping, standing, walking, working, yard work, lifting and driving a car. Petitioner was diagnosed with facet arthropathy (spondylosis), without myelopathy, low back pain, lumbar degenerative disc disease and spinal stenosis. He was scheduled for an epidural steroid injection. He was also told to continue his Advil and she added Gabapentin. (PX8 at 10; RX 6).

Petitioner underwent an epidural steroid injection at L5-S1 on March 7, 2011, performed by Dr. Paul Juergens at Southern Illinois Pain Management. (PX8 at 7)

On March 22, 2011, Petitioner returned to Southern Illinois Pain Management reporting no relief from his pain, although he felt the numbness and tingling in his right foot was a little better. (PX8 at 5; RX 6)

On March 28, 2011, Petitioner underwent a second epidural steroid injection at L5-S1 slightly to the right of midline. (PX8 at 4)

On April 13, 2011, Petitioner returned to Southern Illinois Pain Management reporting a little relief following the injections, but also describing his condition as worsening. Petitioner told the PA that he would prefer to follow up with Dr. Hayward rather than undergo another injection. (PX8 at 2; RX 6)

On April 27, 2011, Petitioner returned to see Dr. Hayward's PA-C, Chris Hodges. (PX9 at 24) The note documented only temporary relief following injections. Petitioner was noted to have predominantly right lower extremity pain although some prior back pain in previous months had included the left lower extremity. Petitioner reported being unable to work due to discomfort. Petitioner still had sensory changes in the L5 distribution. Petitioner was not able to tolerate his symptoms, and wished to discuss surgical intervention with Dr. Hayward. (PX 9; RX 5)

On May 7, 2011, Petitioner was seen by Dr. Hayward. (PX9 at 23; RX 5) Petitioner's subjective complaints included continuing right leg pain, primarily below the calf and right foot, seemingly in the L5-S1 distribution. Dr. Hayward noted moderate to severe foraminal narrowing at L4-5 and L5-S1 on the left compressing the exiting nerve roots, and Petitioner's greatest areas of foraminal narrowing occurred at L2-3 and L4-5 on the right. Dr. Hayward referred Petitioner for a lumbar myelogram and post myelogram CT, and flexion/extension x-rays of the lumbar spine.

On May 18, 2011, Petitioner underwent a lumbar myelogram and post myelogram CT at Memorial Hospital of Carbondale. (PX7 at 26-27; 30-31) The lumbar CT revealed disc herniations at L2-3 and L3-4 lateralizing to the right, severe degenerative changes to the facet joints at L4-5, and a mild disc bulge at L4-5 as well as minimal anterolisthesis, and a disc bulge at L5-S1. (PX7 at 26-27) Lumbar x-rays from the same date confirmed the presence of spondylolisthesis at L4-5. (PX7 at 28)

On May 25, 2011, Petitioner returned to Dr. Hayward; however, due to a tornado warning, Dr. Hayward was unable to review Petitioner's CT myelogram. (PX9 at 16; RX 5). Dr. Hayward indicated his intent to speak with Petitioner later by telephone. Dr. Hayward noted that Petitioner was walking with an antalgic gait. He documented complaints of severe right leg pain with pain radiating into both the L4-5 and L5-S1 distributions. Dr. Hayward felt Petitioner would probably need a facetectomy with diskectomy, interbody spacer at L4-5, and L5-S1 with instrumentation and SSEP monitoring. (RX 5)

On May 27, 2011, Petitioner was again seen by Dr. Hayward. (PX9 at 15) Dr. Hayward noted the lumbar myelogram showed an L4-5 and L5-S1 right radiculopathy as well as low back pain related to his degeneration and facet arthropathy and neural foraminal stenosis. Petitioner was noted to have bilateral spondylitis at L4-5 and Grade 1 spondylolisthesis at L4-5. Dr. Hayward recommended a transforaminal lumbar interbody fusion at L4-5 and L5-S1 on the right, and decompression and discectomy at L2-3 and L3-4 on the right. Dr. Hayward wrote, "I feel that the patient's Grade 1 spondylolisthesis at L4-5 and disc desiccation at L4-5 and L5-S1 is causing his low back pain." He also noted that Petitioner had a combination of disc/osteophyte complex at multiple levels. Dr. Hayward chose not to perform a fusion at L2-3 and L3-4 due to the risk of adjacent segment disease although he noted a considerable amount of foraminal narrowing due to facet hypertrophy at those levels. (RX 5)

On June 23, 2011, Dr. Hayward performed transforaminal interbody fusions at L4-5 and L5-S1 on the right with laminectomy and discectomy at L3-4 on the right and a laminectomy at L2-3 on the right. (PX9 at 11)

On July 18, 2011 Dr. Eaton issued a note pertaining to Petitioner and his recent back surgery. Dr. Eaton indicated that he had last seen Petitioner on March 11, 2010 and had no knowledge as to his current condition. (PX 4)

On July 22, 2011, Petitioner returned to Dr. Hayward reporting dramatically improved leg and ankle pain. X-rays demonstrated excellent placement of the hardware and spacer. Dr. Hayward referred Petitioner for physical therapy. (PX 9 at 9)

In a note dated August 8, 2011, Dr. Eaton discussed payment of his bills, indicating that Bruce Zoller had paid a total of $600.00 for treatment Petitioner had received from "2-23-12[sic][3] thru 9-7-07." He also wrote that he had treated Petitioner seven times between September 23, 2008 and October 31, 2008 for which Bruce Zoller had paid $188.00. (PX 4)

On September 2, 2011, Petitioner returned to Dr. Hayward, who described Petitioner as "ecstatic" and very pleased with the outcome of his surgery. Petitioner was doing great. He wished to ride his horse but was told not to do so. (PX9 at 7) He was released to drive and instructed to wean out of his brace completely. Petitioner's leg pain was reportedly completely resolved, and Petitioner was no longer taking pain medication. Petitioner declined additional physical therapy and was told to return in twelve weeks for a CT scan.

[3] Should be 2/26/07

On November 14, 2011, Petitioner underwent a CT scan of his lumbar spine, without contrast, performed at Memorial Hospital of Carbondale. (PX7 at 9) The CT scan showed, *inter alia*, questionable spinal nerve root impingement that was not definitively excluded. (PX7 at 10)

On November 22, 2011, Petitioner was seen by Dr. Hayward, who reviewed the CT scan and stated it showed some evidence of bony growth particularly along the facet joints and around the screws, but there was some bone growth within the spacers that was not yet complete. Petitioner described his pain level as a "1" at most. He was noted to be doing extremely well. (PX9 at 4) Dr. Hayward recommended Petitioner return in six to eight months for a repeat CT scan. Dr. Hayward noted that as of January 1, 2012, Petitioner would not be able to afford any additional tests or procedures due to the high co-pay and Dr. Hayward stated he would settle on an x-ray.

On June 22, 2012, Petitioner returned to see Dr. Hayward. (PX9 at 3) Petitioner was reportedly doing extremely well. He had some pain complaints but described them as tolerable. He also reported some limitations with daily activities. X-rays demonstrated good placement of screws and alignment of the lumbar spine. Dr. Hayward recommended Petitioner follow up in one year with a CT scan and flexion/extension films of the lumbar spine, at which point Dr. Hayward stated he would most likely release Petitioner. Petitioner also requested a State of Illinois Disability Identification Card which the doctor signed, indicating Petitioner was at "Class 2." Petitioner did not return to Dr. Vaught's office following this visit. (PX9)

Petitioner has undergone no further medical treatment for his low back since June 22, 2012.

On August 6, 2012, Petitioner's Application for Adjustment of Claim in case #12 WC 26843 was filed. Petitioner alleged an accident date of December 1, 2010 when he was "lifting sheet rock and roofing shingles to customer, Alongi's Restaurant, in the regular course of employment." (AX 2, RX 1)

On August 6, 2012, Petitioner's Application for Adjustment of Claim in case # 12 WC 26857 (this claim) was filed. Petitioner alleged an accident date of "February 2007" due to "loading and unloading of sheet rock and roofing shingles in the regular course of employment." (AX 4, RX 1)

On September 27, 2012 Petitioner's Application for Adjustment of Claim in case # 12 WC 33621 was filed. Petitioner alleged an accident date of March 1, 2011.[4] (IWCC website)

On September 27, 2012 Petitioner's Application for Adjustment of Claim in case # 12 WC 33656 was filed. Petitioner alleged an accident date of January 12, 2011 due to "repetitive trauma from loading and unloading of sheet rock and roofing shingles in the regular course of employment." (IWCC website; RX 1)

[4] RX 1 contains an unfiled/unnumbered Application for Adjustment of Claim with an accident date of "December 2010." This may be the same claim with injuries being attributed to "loading and unloading of sheet rock and roofing shingles."

On April 2, 2013 Petitioner's Application for Adjustment of Claim in this case (# 13 WC 10760) was filed. Petitioner alleged an accident date of September 2, 2008 while "lifting 2 X 8 pieces of lumber in the regular course of employment." (AX 6; RX 1)

On April 3, 2013 Petitioner's Application for Adjustment of Claim in case # 13 WC 10931 was filed. Petitioner alleged an accident date of January 4, 2011 due to "lifting in the regular course of employment." (AX 8; RX 1)

On April 3, 2013 Petitioner's Application for Adjustment of Claim in case # 13 WC 10922 was filed. Petitioner alleged an accident date of January 11, 2011 due to "repetitive trauma from loading and unloading building materials in the course of employment." (IWCC website; RX 1)

On April 3, 2013 Petitioner's Application for Adjustment of Claim in case # 13 WC 10928 was filed. Petitioner alleged an accident date of December 7, 2010 due to "repetitive trauma from loading and unloading of sheet rock and other building materials at the residence of customer, Carl Goldman, in the regular course of employment." (IWCC website; RX 1)

Report and Deposition of Dr. Vaught

By letter dated February 12, 2015 Petitioner's attorneys wrote to Dr. Kevin Vaught about the records review he had agreed to perform. The letter referenced all of Petitioner's pending accident dates. Counsel advised Dr. Vaught that it "was their belief" that Petitioner's symptoms were caused or aggravated by two separate incidents while Petitioner was working for Respondent in December of 2010 and/or January of 2011. According to the letter:

> The first injury occurred while [Petitioner] was picking up returned sheet rock from a customer's house. Six or seven sheets were returned. The sheet rock was four by twelve and 5/8 of an inch in width. Each sheet weighed approximately 100 pounds, and the package contained two sheets. [Petitioner] informed us he had to stoop to maneuver the sheet rock through the doorways of the house, and coming out of the house he felt a burning sensation in his low back.
>
> The second injury occurred when [Petitioner] was delivering the same size sheet rock to a restaurant in DuQuoin. [Petitioner] informed us as he was carrying a packet of the same size sheet rock referenced above in to the restaurant with another person. That other person adjusted his hands which twisted the sheet rock and placed greater weight on [Petitioner.] [Petitioner] stated he felt pain in his low back following this incident. (PX 2, Resp. Ex. 1, pp. 1-2)

Dr. Vaught was provided with a brief summary of Petitioner's treatment beginning on January 13, 2011 and advised of Petitioner's history of intermittent chiropractic care for his low back. Records pertaining to all of the foregoing were included. The doctor was further advised that "[b]ased on [Petitioner's] medical history as well as his expected testimony [Petitioner's attorneys] believed [his] low back and leg symptoms as first documented on January 13, 2011 in the records from Wittenauer Chiropractic were caused or aggravated by the incidents at work where [Petitioner] was lifting drywall in the weeks prior to January 13, 2011." (PX 2, Resp. Ex. 1, p. 3)

Petitioner was examined by neurosurgeon Dr. Vaught, Regional Brain & Spine, in Cape Girardeau, Missouri on April 6, 2015.

A written report of the visit followed on/about May 1, 2015. (PX1) In a letter dated May 1, 2015, FNP-BC Debra Alexander (associated with Regional Brain & Spine) issued a cover note regarding the request for an opinion letter on Petitioner. A summary of the consultation note was included. It was noted that Petitioner sought social security disability because he couldn't return to his heavy physical demand labor. Petitioner also denied the need for evaluation or treatment of any lower back symptoms at the time of the exam. Ms. Alexander further noted "My opinions are within a reasonable degree of medical certainty." (PX 1, p. 10)

The consultation note stated that Petitioner gave a history of an onset of symptoms following "two separate work injuries occurring on or about December of 2010 or January of 2011." (PX1 at 1) Both injuries involved carrying sheet rock. Dr. Vaught noted that the first incident involved carrying returned sheet rock out of an individual's home. (PX 1 at 1)

Petitioner described his initial symptoms following his two work accidents as stinging, burning and aching in his lower back, which progressively worsened. (PX1 at 1) He had not worked since January 10, 2011 due to his symptoms. He was treated operatively by Dr. Hayward, and his overall condition improved following lumbar surgery. Dr. Vaught was under the impression Petitioner was unable to return to his heavy physical demand occupation due to work restrictions that had been recommended by Dr. Hayward. (PX 1 at 1)

Dr. Vaught noted Petitioner's subjective complaints on April 6, 2015 included stinging, burning, and aching, which Petitioner modified with his activities. (PX1 at 1) He denied any post-operative complications, and stated he was pleased with his care both before and after surgery. (*Id.*) His pain was rated as 1 out of 10.

Dr. Vaught documented normal motor, sensory, and reflex exams. (PX1 at 3) Range of motion of the lumbar spine was full, and straight leg raise tests were negative. (PX1 at 4)

Dr. Vaught reviewed Petitioner's February 8, 2011 lumbar MRI and stated it showed degenerative disc disease at L2-3 with a small central disc bulge and mild right foraminal narrowing; degenerative disc disease at L3-4 with a broad based disc bulge and a right herniated disc with moderate bilateral foraminal narrowing; degenerative disc disease at L4-5 with a broad based disc bulge and Grade 1 spondylolisthesis and moderate foraminal narrowing; and

degenerative disc disease with moderate foraminal narrowing at L5-S1.The worst foraminal narrowing was on the right at L4-5 and on the left at L5-S1. (PX1 at 4)

Dr. Vaught also reviewed Petitioner's myelogram and post-CT myelogram from May 18, 2011 and Petitioner's lumbar CT scan from November 14, 2011. The May 18, 2011 post-CT myelogram showed a right herniated disc at L2-3, a broad-based disc bulge at L3-4, Grade 1 degenerative spondylolisthesis at L4-5, and a herniated disc at L5-S1 with moderate to severe foraminal stenosis. (PX1 at 5)

Dr. Vaught opined Petitioner's low back and lower extremity symptoms were caused by Petitioner's work accidents. He reasoned that prior to his accidents, Petitioner was not seeking medical care for any active low back or leg problem and Petitioner's mechanism of injury was consistent with the pathology Dr. Vaught observed on Petitioner's diagnostic scans, and was consisted with Petitioner's pre-operative symptoms. (PX1 at 5-6) He felt, certainly, the lifting incidents described by Petitioner aggravated the pathology Dr. Vaught observed on Petitioner's imaging studies. (PX1 at 5). He related the need for Petitioner's treatment, including his lumbar surgery, to his work accidents. (PX1 at 8)

Dr. Vaught believed Petitioner was at maximum medical improvement (MMI) as it related to his work accidents. He placed a permanent 50 pound lifting restriction on Petitioner, with no repetitive bending, twisting or lifting, and no overhead work. (PX1 at 6)

Dr. Vaught was deposed on June 28, 2015. He is a board-certified neurosurgeon and independent medical examiner. (RX2 at 6) Dr. Vaught testified that he examined Petitioner on April 6, 2015 and reviewed his medical records around that same time. He prepared and signed a report containing his findings and conclusions. (RX2 at 7, see also RX1)

Dr. Vaught testified that Petitioner related two separate work accidents occurring in December of 2010 and early in January of 2011. Both involved carrying sheet rock. He testified that the first incident was while Petitioner was carrying sheet rock out of an individual's home and the second incident occurred while Petitioner was taking sheet rock off a forklift at a customer's home. (PX2 at 8) Following the incidents, Petitioner began developing stinging, burning, and aching in his low back, which progressively worsened. These symptoms never resolved on their own. (PX 2 at 9)

Dr. Vaught also testified that Petitioner told him he had experienced intermittent back problems prior to his work accidents. He had previously seen a chiropractor intermittently, but had not recently seen anyone for any actual problems prior to the two 2010 work accidents. (PX2 at 9) Dr. Vaught testified there was no record of any treatment or complaints of either low back or lower extremity pain after March 30, 2010. (PX2 at 23)

Dr. Vaught reviewed the January 13, 2011 note from Wittenauer Chiropractic. (PX2 at 10) Dr. Vaught also testified that the chiropractor noted an onset date of December 30, 2010. Dr. Vaught testified that such a history was consistent with the history provided to him by Petitioner. Petitioner's subjective complaints documented in that note were right sacroiliac articulation and right sciatica, both rated at 10 out of 10. (PX2 at 10) This was described as a new problem.

((PX2 at 10) The documented date of onset in the note was December 30, 2010, which was consistent with the timeframe given by Petitioner on April 6, 2015. (PX2 at 11)

Dr. Vaught also reviewed the March 30, 2010 note from Wittenauer Chiropractic, which was several months prior to the January 13, 2011 visit. (PX2 at 11-12) On that date, Petitioner described left, not right, sacroiliac articulation, and left, not right, lower back pain, and left neck pain. (PX2 at 12) He rated his pain at only 6 out of 10 on that date. (PX2 at 12)

Dr. Vaught further testified concerning his review of Petitioner's medical records from before the 2010 work accidents. (PX2 at 13, 22) According to him, none of those records documented either the type or the severity of the symptoms described in Petitioner's January 13, 2011 record from Wittenauer Chiropractic. (PX2 at 13) Dr. Vaught testified that Dr. Hayward's notation that Petitioner's symptoms began in January of 2011 was consistent with what Petitioner told him. (PX 2 at 16-17) He also testified that Petitioner did not relate to him waking up one morning with back pain (as referenced in the history given at SI Pain Management). (PX 2 at 18) Dr. Vaught felt that none of Petitioner's records from any other provider documented the same severity or type of symptoms as were documented on January 13, 2011. (PX2 at 22)

Dr. Vaught also reviewed Dr. Cochran's January 26, 2011 note. (PX2 at 13) Petitioner's visit was a little more than a week following Petitioner's visit to Wittenauer Chiropractic. (PX2 at 13) Dr. Cochran's note documented severe low back pain and right lower extremity pain for several weeks, which Petitioner first noticed after lifting drywall. (PX2 at 14-15) Dr. Vaught testified this history was consistent with the history given to him by Petitioner on April 6, 2015. (PX2 at 15)

Dr. Vaught reviewed Petitioner's February 8, 2011 lumbar MRI and testified his biggest issue was an L3-4 disc herniation on the right. (PX2 at 15) He also had Grade 1 spondylolisthesis at L4-5, and significant foraminal narrowing at L2-3, L3-4, L4-5, and L5-S1. (PX2 at 15) This pathology was consistent with Petitioner's subjective complaints of pain discussed in the January 13, 2011 record from Wittenauer Chiropractic, and Dr. Cochran's chiropractic records. (PX2 at 15)

Dr. Vaught also testified that the pathology he observed on the lumbar MRI was also consistent with the objective physical findings documented by Dr. Cochran on January 26, 2011. (PX2 at 15) Dr. Vaught testified that Dr. Cochran suspected a radicular problem, which based on the exam and history and MRI, showed findings correlating anatomically to the distribution Dr. Cochran suspected. (PX2 at 15-16)

Dr. Vaught testified that Dr. Hayward's initial treatment record documented Petitioner's symptoms beginning in January of 2011. (PX2 at 16) He felt this was consistent with the timeframe given to Dr. Vaught by Petitioner and Dr. Hayward's documented subjective complaints and objective physical findings were consistent with the pathology observed on the MRI. (PX2 at 16 - 17)

Dr. Vaught also reviewed the records from Southern Illinois Pain Management. (PX2 at 17) The March 2, 2011 note documented complaints of pain, numbness, and aching, as well as

right foot burning, aching, and numbness. (PX2 at 17-18) The note documented Petitioner describing his job duties for Respondent as quite a physical job. (PX2 at 18) Dr. Vaught testified the history of Petitioner's onset of symptoms contained in this note was consistent with what Petitioner told about the two acute events. (PX2 at 18)

According to Dr. Vaught, Petitioner underwent an L4-5 and L5-S1 transforaminal lumbar interbody fusion with instrumentation, then a right L3-4 microdiscectomy and medial facetectomy and foraminotomy, and a right L2-3 laminectomy and foraminotomy. (PX2 at 21) Petitioner did well following surgery. (PX2 at 21)

Dr. Vaught personally met with Petitioner and his wife on April 6, 2015. (PX2 at 25) He took a history from Petitioner and performed a physical exam. His opinions are his own. (PX2 at 25) Dr. Vaught's nurse practitioner, Debra Alexander, assisted with the examination and preparation of Dr. Vaught's report. (PX2 at 24) Dr. Vaught personally reviewed the medical records, and Ms. Alexander acted as a scribe. (PX2 at 24) She translated the handwritten patient form completed by Petitioner[5] into the electronic format, and assisted with obtaining the history from Petitioner. (PX2 at 24) Dr. Vaught routinely has Ms. Alexander assist in the transcription of reports; however, Dr. Vaught reviews all the reports prior to signing. (PX2 at 25)

Dr. Vaught testified that he felt Petitioner was at maximum medical improvement (MMI) and that he needed a permanent 50 pound lifting restriction, as well as restrictions on bending, twisting, and squatting. (PX2 at 25-26) Dr. Vaught causally related the need for these restrictions to Petitioner's work accidents. (PX2 at 28-29)

Dr. Vaught causally related Petitioner's low back and lower extremity symptoms to the two sheet rock lifting incidents Petitioner reported to him. (PX2 at 26) Dr. Vaught testified the disc herniation at L3-4 on the right "was a direct result of that work-related injury." (PX 2 at 27) 27) The degenerative changes were also aggravated, particularly the foraminal stenosis and spondylolisthesis. (PX2 at 27)

Dr. Vaught testified it was significant that Petitioner was not seeking medical care for an active low back or leg problem prior to his work accidents. (PX2 at 27) He also based his opinions on simply talking to Petitioner and hearing him relay the same history. (PX2 at 27) Further, Dr. Vaught based his opinions on the difference in the severity of Petitioner's pain prior to his work accidents and after. (PX2 at 27) The following exchange then occurred:

> Q. The mechanism of injury that [Petitioner] reported to you, was that consistent with causing or aggravating [his] pathology you previously testified to?
>
> A. Yes. Heaving lifting is one of – one of the causes of a herniated disc and aggravating back pain. He also testified that the mechanism of injury, lifting sheet rock, was consistent with a disc herniation and aggravation of preexisting degenerative lumbar conditions.

[5] Not a part of the record.

Dr. Vaught further testified that Petitioner's treatment, including surgery, was reasonable and necessary to relieve Petitioner of the symptoms the doctor believed were causally related to his work accidents and subsequent treatment. (PX2 at 28)

On cross-examination Dr. Vaught acknowledged that the majority of the records he reviewed were from December of 2010 and onward. He further testified that the records he reviewed pre-dating December of 2010 did not describe a severe radicular pain syndrome consistent with a herniated disc. (PX 2 at 30) Dr. Vaught described Petitioner's pre-December of 2010 complaints of intermittent back pain and sacroiliac joint discomfort as transient in nature. Dr. Vaught further testified that he was not provided with any indication of work accidents prior to December of 2010. Furthermore, he did not recall that the medical records he reviewed related or indicated any work accidents prior to December of 2010. (PX 2 at 31)

Dr. Vaught confirmed on further cross-examination that his causation opinions were related to alleged accidents in either December of 2010 or January of 2011. (PX 2 at 31)

On additional cross-examination Dr. Vaught acknowledged receiving a letter from Petitioner's attorney along with medical records to review. That letter was marked as RX 1 to the deposition. Dr. Vaught acknowledged that the history provided to him regarding Petitioner was contained in that letter and was the same history Petitioner provided to him. (PX 2 at 33-34)

Dr. Vaught agreed that there was no mention in Dr. Wittenauer's January 13, 2011 note of any incident wherein Petitioner's back was hurting after lifting drywall. (PX 2 at 34, 35) He agreed that Dr. Wittenauer's notes reference an onset date of December 30, 2010. (PX 2 at 35) Dr. Vaught also agreed that the doctor's notes from that visit state that nothing in particular aggravated Petitioner's problems because they were always there. (PX 2 at 36) Dr. Vaught agreed there was nothing in Dr. Wittenauer's January 1, 2011 note stating Petitioner hurt his back after lifting drywall. He also agreed that Dr. Hayward's record of February 23, 2011 states Petitioner's low back and right hip pain began in January of 2011. He agreed there was no mention in that office visit of an incident involving the lifting of drywall in December of 2010 or January of 2011. Dr. Vaught also agreed that the SI Pain Management record of March 2, 2011 contains a history wherein Petitioner indicated his back pain began when he woke up on January 12, 2011 and that there was no new injury or trauma. (PX 2 at 36-37)

Dr. Vaught testified that chronic pain is defined as pain in the same distribution or location that occurs for more than six months. He agreed that the DuQuoin Chiropractic records from 2007 indicate Petitioner was getting consistent treatment for severe low back pain for several months. He agreed that the April 6, 2007 entry, while hard to read, suggests Petitioner was having some pain after doing extensive lifting and that on May 25, 2007 he had back pain after moving shingles and sheetrock. He also agreed there are references to heavy lifting and back pain on July 16th and July 27th. Dr. Vaught also agreed that the September 23, 2008 entry states Petitioner was having low back pain that started three weeks earlier on the left after moving two by eights at work and that it dissipated slowly after two to three days but about two week earlier he began having pain on the right side with radiation to the front side of his leg to

the knee. He also agreed that on September 25, 2008 the doctor noted Petitioner's low back was still painful and radiating down around the right leg. He agreed that those records indicated Petitioner had experienced low back pain prior to December of 2010. (PX 2 at 37 -41) Dr. Vaught testified that it appeared Petitioner went to the chiropractor 36 times between February and September of 2007 which he would define as "intermittent" and not constant. (PX 2 at 42)

Dr. Vaught further testified on cross-examination that while Petitioner had low back pain during 2007 he was primarily diagnosed with SI joint dysfunction which is back pain but not mechanical low back pain or radicular pain. (PX 2 at 44) He also acknowledged that the doctor's notes from that time refer to low back pain ("lbp"). When asked how the doctor came up with Petitioner's diagnosis of SI joint dysfunction during that period he testified that he was not the doctor then and did not diagnosis Petitioner with it. (PX 2, p. 46)

Dr. Vaught was asked about the dates of injury provided to him. He testified that he did not have a date for the December injury. It was his understanding that the January date was around January 10th. (PX 2 at 47) He further testified that he knew Petitioner last worked on January 10, 2011. When asked if Petitioner ever gave him a specific date of accident, the doctor replied, "I do not have a specific date. He recalls two specific incidents, which are documented here, but I don't have the specific date." (PX 2, p. 48)

Dr. Vaught was asked about a date of injury "3/1/11" as stated on page one of his report. He testified that it was an error as he didn't know where that date came from. When asked if he had received copies of Petitioner's Applications for Adjustment of Claim (one of which referenced a March 1, 2011 accident) Dr. Vaught replied that he had not. (PX 2, p. 49)

Dr. Vaught reiterated that his causation opinion was based entirely upon the history provided by Petitioner at the time of the examination. He also reiterated that such history was the same one contained in the letter from Petitioner's attorney. (PX 2, p. 50)

Dr. Vaught testified that he performed the focal neurologic examination regarding Petitioner's back and legs and Ms. Alexander did a complete neurological examination. He further testified that there is a "glitch" in his office system which is why it appears the letter to Petitioner's attorney was signed by Ms. Alexander. He reiterated that he performed the examination and not Ms. Alexander. Ms. Alexander assisted him in the preparation of the report; however, he reviewed the report. (PX 2 p. 50 – 58)

On redirect examination Dr. Vaught discussed the histories Petitioner provided to his various treating physicians and chiropractors. (PX2 at 69) He further testified that nothing asked of him on cross-examination would change any of his opinions. (PX 2, 61)

On further cross-examination the following exchange occurred:

> Q. …do you have an opinion within a reasonable degree of medical certainty as to whether or not that gap of almost two years [October of 2008 to October of 2010 or January of 2011] is an indication that the problems that

> he sought treatment for in 2007/2008 is not related to the treatment he subsequently had after December, 2010?
>
> A. It was my opinion that the problems that he sought treatment for after December, 2010 was quantitatively different and consistent with a herniated disc. (PX 2 at 65)

On further cross-examination Dr. Vaught was asked about Dr. Wittenauer's note of January 13, 2011. Based upon what was contained in that note, Dr. Vaught was of the opinion Petitioner, on that date, had a herniated disc causing right sciatica; however, he could not testify to a reasonable degree of medical certainty what specific incident caused that pain. (PX 2 at 66) He also testified that he could not state what specific incident was the cause of Petitioner's complaints at the January 14th visit with Dr. Hayward. (PX 2 at 66-67)

On further redirect examination Dr. Vaught was asked if he ever spoke with Petitioner about the histories he gave to the various providers when they met on April 6, 2015. Dr. Vaught testified that Petitioner told him his main priority when he was first seeking care was to get his pain addressed because it was severe and unlike anything he had experienced previously. (PX2 at 69) Petitioner told Dr. Vaught he used his private insurance and he didn't have work comp coverage. (PX2 at 69) Petitioner told Dr. Vaught he was not setting up any sort of workers' compensation claim, he was merely focusing on his pain. (PX2 at 70)

Report and Deposition of Dr. Crane

After Dr. Vaught's deposition and on/about September 18, 2015 Dr. Benjamin Crane performed a records review for Respondent and issued a report thereafter. In a one-page, undated letter addressed to Respondent's attorney, Kelly Phelps, Dr. Crane stated he reviewed the records provided to him concerning Petitioner. Dr. Crane stated:

> [Petitioner] has been under the care of a chiropractor for quite some time but ultimately ended up under the care of Dr. Vaught when he underwent what sounds like a single level TLIF at the L4-5 level for back pain and possibly leg pain. In reviewing the medical record, I do not see any reference to a specific injury at work, with the exception of the Independent Medical Evaluation and ultimate surgery performed by Dr. Vaught. The chiropractic notes failed to state any significant work-related injury for any of his visits dating all the way back to 2007. (RX 2, dep. ex. B)

Dr. Crane was unable to causally relate Petitioner's low back condition to any specific work accident based upon the history contained in the medical record nor could he causally relate the necessity for Petitioner's surgery in June of 2011 to any specific work accident based on the histories contained in the medical records. (RX 2, dep. ex. B)

Dr. Crane was deposed on October 28, 2015. Dr. Crane testified that he is an orthopedic spine surgeon who was board certified in 2010. (RX2 at 5-6) He testified he performed a medical records review at Respondent's attorney's request. (RX2 at 6) He testified he reviewed records from one of Petitioner's chiropractors, the record from Dr. Vaught, and "some of the care by Dr. Hayward." (RX2 at 6)

Dr. Crane admitted he was at a disadvantage in this case because he did not take a history directly from Petitioner. (RX2 at 36-37) He testified that obtaining a history from a patient is almost the most important thing he does when he meets a patient. (RX2 at 8) Dr. Crane likes to know exactly how the patient hurt themselves, and what situation they were in. (RX2 at 8)

Dr. Crane testified that he could not casually relate Petitioner's symptoms and subsequent surgery in 2011 to his claimed work accident based on his review of Petitioner's records, which he testified contained no indication of a work injury that would necessitate Petitioner's back pain. (RX2 at 7)

Dr. Crane testified his report did not identify any specific records that he may or may not have reviewed, other than Dr. Vaught's report. (RX2 at 14-15) He also testified his report referenced a single, unidentified chiropractor. (RX2 at 15) He conceded that a person reading his report would know only that he read a report from Dr. Vaught and from an unidentified chiropractor. (RX2 at 15)

Dr. Crane also testified that his report stated Petitioner had been under the care of a chiropractor "for quite some time." (RX2 at 16) He explained that this referred to Petitioner's chiropractic treatment by Dr. Eaton at Du Quoin Chiropractic Center. (RX2 at 16) Dr. Crane conceded, however, that these records indicated Petitioner was seen for a few months in 2007, followed by a year-long gap. (RX2 at 17). The records also showed chiropractic care in September and October of 2008, followed by a gap of one year and five months. (RX2 at 16)

Dr. Crane also testified that following the one year and five month gap, Petitioner's records then indicated chiropractic visits in March of 2010. (RX2 at 17-18) He noted that the record from Wittenauer Clinic dated March 30, 2010 documented left sacroiliac articulation and left lower back pain, rated at 6 out of 10. (RX2 at 19)

Dr. Crane agreed there was not another record of treatment with Dr. Wittenauer following the March 30, 2010 visit, and further conceded there was no record of any treatment whatsoever for any condition following March 30, 2010, until after December of 2010. (RX2 at 19-20)

Dr. Crane testified that his Petitioner's chiropractic records from March of 2010 documented left-sided symptoms Petitioner rated at 6 out of 10, but his chiropractic records from January of 2011 documented right-sided symptoms he rated at 10 out of 10. (RX2 at 25-26)

Dr. Crane also testified that his reference to workers' compensation claims came not from Petitioner's medical records, but from Respondent's attorney's letter to Dr. Crane. (RX2 at 15-16)

Dr. Crane testified that he recognized the day before his deposition that he misidentified Petitioner's surgeon in his report. (RX2 at 7) He admitted his report stated Petitioner underwent "what sounds like a single level TLIF at the L4-5 level." (RX2 at 20) He testified he reviewed Dr. Hayward's operative report. (RX2 at 20-21) He conceded Dr. Hayward documented not a one-level lumbar surgery, but a four-level lumbar surgery. (RX2 at 22) He testified his own report was inaccurate. (RX2 at 22)

Dr. Crane testified he reviewed Dr. Vaught's record, which contained histories of two specific instances of Petitioner lifting and carrying sheetrock and materials as part of his employment. (RX2 at 23-24) Dr. Vaught's record also stated Petitioner reported he had not returned to work for Respondent since January 10, 2011 because of his symptoms. (RX2 at 24)

Dr. Crane admitted the history of Petitioner's symptoms documented in Dr. Wittenauer's January 13, 2011 note was consistent with the histories of accident documented in Dr. Vaught's report. (RX2 at 26-27)

Dr. Crane admitted Dr. Cochran's note of January 26, 2011 contained a history of severe low back pain radiating into Petitioner's right lower extremity for several weeks. (RX2 at 27). This was also consistent with the histories of accident documented by Dr. Vaught. (RX2 at 27-28).

Dr. Crane testified the January 26, 2011 note from Dr. Cochran documented a history of first noticing symptoms after lifting drywall. (RX2 at 28) Dr. Crane agreed that this reported mechanism of injury was consistent with the histories contained in Dr. Vaught's record. (RX2 at 28)

When asked whether Dr. Cochran's note from January 26, 2011 that Petitioner's symptoms began after lifting drywall was inconsistent with the statement in his report that there was no reference to an injury at work, Dr. Crane was equivocal. (RX2 at 28-29) He testified that while there was a distinct possibility he was referring to a work accident, the record did not specify a date. (RX2 at 29)

Dr. Crane conceded the mechanism of injury documented by Dr. Cochran on January 26, 2011 was documented a few weeks following Petitioner's alleged work accidents. (RX2 at 30) He further conceded that Petitioner's symptoms continued after December 2010 with no gaps in treatment until he had surgery. (RX 2 at 30) This was consistent with the histories documented by Dr. Vaught. (RX 2 at 30)

Dr. Crane admitted Petitioner always had gaps in his chiropractic care of months or even years prior to his alleged work accident, but there were no gaps following his initial visit to Dr. Wittenaeur on January 13, 2011. (RX2 at 31)

Dr. Crane admitted that if the histories of accident contained in Dr. Vaught's record were correct, then those accidents could have caused Petitioner's back and leg pain. (RX2 at 34) Dr. Crane testified that, to a reasonable degree of medical certainty, if Petitioner suffered the two

work accidents he described to Dr. Vaught in December of 2010, those accidents might or could have caused or aggravated Petitioner's low back condition. (RX2 at 34-35) The mechanism of injury as documented by Dr. Vaught could have caused or aggravated Petitioner's low back condition. (RX2 at 35)

Dr. Crane testified he was not offering any opinion as to the reasonableness and necessity of any of Petitioner's treatment, only that the treatment was not causally related to Petitioner's claimed work accidents. (RX2 at 35-36)

Dr. Crane testified he has been performing independent medical examinations or records reviews on behalf of insurance companies and defense attorneys since he came to St. Louis in 2008. (RX2 at 10-11) Approximately 5 to 10 percent of Dr. Crane's practice is dedicated to IMEs. (RX2 at 11) He testified the legal work he performs is split between plaintiffs and defendants. (RX2 at 12)

The Arbitration Hearing

Petitioner's cases proceeded to arbitration on June 13, 2017. At the time of arbitration Petitioner voluntarily dismissed the following claims: 12 WC 33621; 12 WC 33656; 13 WC 10922; and 13 WC 10928. Respondent was represented by Attorney Phelps in case number 12 WC 26843 and 13 WC 10931. Attorney Hoffman represented Respondent in case number 12 WC 26857 and 13 WC 10760.

At the beginning of the hearing Petitioner moved to amend the date of accident in 12 WC 26843 to December 3, 2010, which was granted. Petitioner also moved to amend the date of accident in 12 WC 26857 to February 23, 2007 which was granted and to amend the date of accident in case 13 WC 10931 to December 23, 2010 which was granted.

With regard to case # 12 WC 26843 (D/A – 12/3/10) the disputed issues were: accident; notice; medical bills; temporary total disability benefits; and nature and extent. (AX 1)

With regard to case # 12 WC 26857 (D/A – 2/23/07) the disputed issues were: accident; notice; causal connection; and nature and extent. (AX 3)

With regard to case # 13 WC 10931 (D/A – 12/23/10) the disputed issues were: accident; notice; causal connection; medical bills; temporary total disability benefits; and nature and extent. (AX 7)

With regard to case # 13 WC 10760 (D/A – 9/2/08) the disputed issues were: accident; notice; causal connection; and nature and extent. (AX 5)

Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he is married and his highest level of education was twelfth grade. Petitioner worked for Respondent approximately sixteen years. He last worked for Respondent on January 12, 2011.

Petitioner testified that he worked for Respondent as a delivery handler. In that position he filled customer orders, consisting of shingles, sheet rock, lumber, windows, doors, concrete, concrete blocks, and any other building materials. Petitioner would get an order off the board, pick up the materials, and deliver them to customers. Petitioner further testified that the shingles he handled and delivered came in packages weighing between 75 and 95 pounds per bundle. Additionally, the sheet rock Petitioner handled and delivered weight approximately 100 to 275 pounds per package, depending on the width of the sheet rock. Petitioner testified that sheet rock was 5/8 inches and 12 feet long and weighed approximately 275 pounds.

Prior to the instant claims, Petitioner had never filed a workers' compensation claim.

Petitioner testified that he sustained a work accident in "February of 2007." He explained that he was pulling material out of a bin to load it on the truck and he heard "something" in his back. He thought it was 2 X 8s, 2 X 10s, or 2 X 12s. When asked what part of his body was affected, Petitioner replied that he didn't know for sure but he "knew" it was the lower part of his back. He rated his pain as a "6/10." He went to Bruce Zoller as he "couldn't do it any longer" and Bruce told him to take it easy and see how he did. Petitioner testified that it kept getting worse and he told Bruce he needed to go to the chiropractor and Bruce told him to go. Petitioner also testified that he received some chiropractic treatment from Dr. Eaton and had to start paying for them. He then approached Bruce and told him that wasn't right because it should be workers' compensation since he was hurt pulling materials out of the bin for him. According to Petitioner, Bruce told him that since he paid his health insurance he wanted to keep it off workers' compensation. Petitioner testified that Bruce and Clarence Zoller own the lumber company. Bruce was his boss. According to Petitioner, Bruce Zoller told him he would speak to Dr. Eaton and that Petitioner should keep treating with him. Petitioner testified that he would have filed a workers' compensation claim if Mr. Zoller hadn't told him otherwise.

Petitioner also testified that Dr. Eaton never recommended an MRI or CT scan following the 2007 accident nor was he referred to a surgeon. Petitioner didn't miss any work after the 2007 incident. He would just take it easy when necessary and then return to his regular duties after he felt his strength returning. After some treatment with Dr. Eaton, Petitioner was able to return to full duty work with no restrictions.

Petitioner further testified that he did not undergo any treatment for his low back between October 31, 2007 and September of 2008. He then sustained another accident while lifting shingles and putting them on the laddervator to deliver to some homeowners. As he was getting down to the bottom of a pallet of shingles, he twisted and felt "something" hurt along with pain in the left side of his lower back. He then returned to see Dr. Eaton, the chiropractor. During this time, Dr. Eaton never recommended an MRI or CT scan nor was he referred to a surgeon. He rated his pain as a "5/10."

Petitioner testified that he told the secretary, Beverly Wisely, and Bruce Zoller about this accident. Mr. Zoller, according to Petitioner, told him he would speak to the doctor and once he was better the company would pay the doctor. He didn't file a workers' compensation claim on this accident for the same reason as the earlier one. Petitioner didn't miss any time from work because he just reported to work and took it easy when needed. He eventually returned to full duty work without any restrictions.

Petitioner further testified that he didn't undergo any further treatment after the 2008 incident until March of 2010 when he returned to Dr. Eaton; however, he didn't feel any of that treatment was due to a work accident. He also recalled seeing Dr. Wittenauer on March 30, 2010 but thought it was for his shoulder and upper back. When asked if he would disagree with the records if they reflected left-sided sciatic pain, Petitioner replied "No." Petitioner continued working full duty for Respondent during this time and up through December of 2010.

Petitioner testified that on December 3, 2010 he delivered an order to Alongi's Restaurant in Du Quoin, Illinois, consisting of 11 sheets of 4 X 12 5/8 in. sheet rock and 2 x 4s for an addition to the restaurant. He reviewed a work order for this delivery dated December 3, 2010 confirming this delivery. (PX10) Petitioner testified he did not have access to this work order after he was no longer employed by Respondent, and he also did not have access to that work order at the time he filed any of his Applications for Adjustment of Claim. It was not until PX 10, and other, work slips were provided to his attorney that Petitioner had access to this work slip. Petitioner testified that once he reviewed PX 10 and other work tickets, he was able to pinpoint the date of a work-related injury he sustained, which was December 3, 2010.

Petitioner testified that the packets of sheet rock he deliverd to Alongi's weighed approximately 275 pounds per packet. He, an Alongi's employee, and another gentleman were helping Petitioner. Petitioner explained that he had one end of the packet of sheet rock and the employee had it on the other end, but the packet would bow when you picked it up to take it off the forks. When they stood to lift the sheet rock off the fork lift, it jerked, and almost took Petitioner to the ground. Petitioner testified he felt a bad snap in his low back, and felt pain in his low back and right lower extremity following this accident. He rated his pain as 10 out of 10. He also felt a burning and stinging sensation. Petitioner testified that prior to December 3, 2010, he had never experienced symptoms like the ones he experienced after this accident because this time he felt a snap and a burning and stinging sensation. Petitioner testified these symptoms were very different that the ones he had experienced nine months earlier in March of 2010.

Petitioner testified he notified his boss, Bruce Zoller, about this accident. According to Petitioner, Mr. Zoller told him to take it easy and go to the chiropractor. Petitioner testified that he continued to work despite his symptoms, albeit on modified duty. He testified he did not seek immediate treatment, but knew he had vacation coming up between Christmas Day and New Year's Day, and hoped if he took it easy until vacation that his symptoms would improve. He testified his symptoms did not improve.

Petitioner testified that until the Christmas break he continued to work but his symptoms didn't go away. They then recurred on December 23, 2010, when he made a delivery to a customer, Carl Goldman, consisting of 16 4 X 8 by 1/2 in. pieces of sheet rock. After that

incident, his symptoms continued to worsen. Petitioner reviewed another work order for this delivery dated December 23, 2010 confirming this delivery (PX11).

Petitioner testified he did not have access to PX 11 after he was no longer employed by Respondent, and further did not have access to PX 11at the time he filed any of his Applications for Adjustment of Claim. It was not until PX 11, and other, work slips were provided to his attorney that Petitioner had access to this work slip.

Petitioner testified that once he was able to review PX 11and other work tickets, he was able to pinpoint the date of a work-related injury he sustained, which was December 23, 2010. (PX11).

Petitioner testified that on December 23, 2010, he was delivering sheet rock to, and picking up returns from, Mr. Goldman's house. According to Petitioner, Mr. Goldman was constructing a new home, and Petitioner was required to duck low to go out from the doorways. Petitioner was carrying three pieces of sheet rock, weighing approximately 75 pounds each, out of Goldman's house. He ducked low to exit a doorway, and felt his low back pop again in the same place as he felt after the incident at Alongi's.

Petitioner testified he had the same pain, stinging, and burning in his low back and right lower extremity as he did following the incident at Alongi's three weeks prior. He rated his pain following this incident as 10 out of 10.

Petitioner testified he notified Mr. Zoller of this accident and Mr. Zoller told him to take it easy, that vacation was coming up, and perhaps Petitioner would get better while off on vacation.

Petitioner testified it was commonly known that Mr. Zoller would not allow injured workers to receive workers' compensation benefits because he paid for their group health insurance. Petitioner testified it was that way for his 16 years of employment.

Petitioner testified his symptoms did not get better during the holiday; rather, they kept getting worse. He testified he attempted to return to work in January of 2011, and worked for around seven days, during which he just sat around as he could hardly do anything.

Petitioner testified that around January 10, 2011, he got up to go to work and could not even bend over to pull his socks up or his shoes on. He called Mr. Zoller and told him about his condition. According to Petitioner, Mr. Zoller told him to just stay home and see if his condition improved. Petitioner testified that his condition did not improve and he was unable to return to work again.

Petitioner was required to seek treatment for his condition. His pain and stinging in the right side of his back and his right leg was so bad he could hardly stand it. He rated his pain as 10 out of 10 at that time.

Petitioner testified that he first sought treatment at Wittenauer Chiropractic in January of 2011. He was experiencing pain in the right side of his back. He also noticed a stinging sensation and right leg pain. When asked if he happened to tell anyone at Wittenauer Chiropractic about his injury he testified that he thought he did but he couldn't swear to it.

Petitioner testified he also saw Dr. Cochran, another chiropractor, in January of 2011. He started paying him and told the doctor it wasn't right that he was paying for the treatment when it happened at work but his employer wouldn't let him proceed under workers' compensation since it provided him with his health insurance. According to Petitioner, Dr. Cochran got hold of Bruce Zoller and he gave Petitioner his money back. From then on the doctor couldn't do anything for him and he referred him to Dr. Hayward.

Petitioner testified when he first came under the care of Dr. Hayward, he saw Dr. Hayward's physician's assistant. He remembered the PA's name was Chris. He testified he told Chris he hurt his back working for Respondent and that it should be processed as a workers' compensation claim, but because of Mr. Zoller's statements and policy concerning injured workers not being entitled to workers' compensation benefits because Respondent provided group health insurance, Petitioner told Chris he was required to process the treatment under his group health insurance.

Petitioner testified that PA Chris was the last medical provider to whom he gave a history of his two work accidents in December of 2010 because of Mr. Zoller's statements. He saw at least three more PAs prior to seeing Dr. Hayward, but did not mention to them or to Dr. Hayward his December 2010 work accidents because of Mr. Zoller's requirement that Petitioner use his group health insurance.

Petitioner was asked if he told Dr. Hayward or any of the PAs about the work accidents at Alongi's and Mr. Goldman's and he replied "no" because he was in so much pain at that time he could hardly stand.

Petitioner testified he underwent lumbar injections at Southern Illinois Pain Management. He testified he did not give anyone at Southern Illinois Pain Management a history of his accident at Alongi's or at Goldman's house. Petitioner did not recall giving a history of his pain beginning on January 12, 2011. He testified January 10, 2011 was the date he could not get his socks on, and testified that pain was continuing pain from the accidents at Alongi's and at Carl Goldman's house. His pain did not begin in January of 2011; rather, his pain got so severe at that time that he could not put his socks or shoes on.

Petitioner testified he eventually underwent lumbar surgery on June 23, 2011 performed by Dr. Hayward. He testified he did fine following surgery. He testified he is unable to lift over 50 pounds, and can hardly do any stooping because of ongoing pain. He still has pain in the same locations in his low back and right leg and his functions are limited greatly due to this pain. Petitioner is unable to perform his job duties for Respondent.

Petitioner testified his group health insurance at the time was an 80/20 plan, requiring him to pay 20 percent of his charges out of pocket. He testified he paid more than $5,000.00 out-of-pocket for medical treatment in 2011.

Petitioner testified he last saw Dr. Hayward in 2012, and had to pay for that visit himself, as he no longer had group health coverage. This included paying for an x-ray of his lumbar spine. His group health was cancelled as of January 1, 2012. Dr. Hayward wanted to see Petitioner again, and wanted Petitioner to obtain a CT scan or MRI. Petitioner explained he could not afford either of those scans, and Dr. Hayward settled for an x-ray, which was all Petitioner could afford. He has not returned to Dr. Hayward.

Petitioner testified that in 2015 he met with Dr. Kevin Vaught in Cape Girardeau, Missouri. He testified he actually met with Dr. Vaught, not just Dr. Vaught's PA, and that Dr. Vaught actually performed a physical examination on him. Petitioner testified Dr. Vaught placed permanent restrictions on him, and that Respondent never offered to accommodate those restrictions or bring Petitioner back to work. Respondent never offered Petitioner vocational rehabilitation services or any assistance any sort of job search.

Petitioner testified he has never heard of Dr. Benjamin Crane, and that he had never been examined by him.

On cross-examination, Petitioner testified his pain was a "10/10" after he got hurt in early December of 2010. He agreed that he didn't get any treatment but he continued to show up for work. When asked if he actually worked, he replied he did not as he mostly sat around because he could do very little. He denied making any deliveries after December 3rd. He then testified that he started making some deliveries because he guessed the inflammation went down but those deliveries didn't begin until shortly before December 21, 2010. Petitioner then clarified that he didn't think he did for "maybe four to six days." Petitioner was then asked about a delivery of wood boxes to Taylor Brothers on December 21, 2010. He testified he drove the delivery truck to Taylor Brothers, but they unloaded the materials themselves because he was unable to move them.

Petitioner was also asked about a delivery on December 20, 2010 to Dave Kent. He testified Mr. Zoller had the yard boy load the materials on the truck. Petitioner drove the truck to Dave Kent's, and they unloaded the materials.

Petitioner was asked about a delivery on December 16, 2010 to Jackie Davidson. He testified it was the same as the previous question, that Petitioner was able to drive the truck, but was unable to either load or unload the truck.

Petitioner testified he continued to make deliveries, without loading and unloading the truck, until January 10, 2011 when he was unable to return to work due to pain. Prior to January 10, 2011, he would show up every day and would either sit around, and/or sometimes drive the delivery truck, but did not load or unload the truck.

Petitioner reviewed several work orders from December 1, 2010 to January 11, 2011. (RX7). He testified that some of these deliveries were not made by him. The deliveries he made during that period contain his initials at the bottom.

Petitioner confirmed that on December 1, 2010, prior to the Alongi's work accident, he made deliveries to Scarby Funeral Home, Heartland Mechanical, and Du Quoin High School. He also confirmed that on December 2, 2010, also prior to the Alongi's work accident, he made deliveries to Terry Marks, Carl Goldman, and to Brad Galli.

Petitioner testified that deliveries following December 3, 2010 were loaded by Respondent's other employees and unloaded by the customers themselves, as he was unable to load or unload the truck due to his work injury of December 3, 2010.

Petitioner testified that his last day of work for Respondent was January 10, 2011. He was then shown a delivery ticket for January 11th and agreed it had his initials on it but he had no explanation. He thought the 10th was a Tuesday morning and the last day he went in to work. He agreed that the work slips show he continued to work and that he drove the truck and forklift making deliveries. He also agreed that he sought no medical treatment in December of 2010.

Petitioner confirmed on cross-examination that the first time he sought medical treatment following his injuries at Alongi's and at Goldman's house was on January 13, 2011 with chiropractor Dr. James Wittenauer. Dr. Wittenauer's note documented that Petitioner's symptoms were worse when he did nothing because they were always there. Petitioner testified this was true after he was injured. He testified he may have failed to mention his December of 2010 work accidents at that visit, but those accidents were the reason he was there. Petitioner testified the notation in Dr. Wittenauer's records of symptoms beginning December 30, 2010 was inaccurate, and that someone must have written it down wrong.

Petitioner agreed that he underwent chiropractic treatment for left-sided low back pain beginning in February of 2007. Despite an entry in Dr. Eaton's September of 2008 records to the contrary, Petitioner did not believe he had prior right-sided low back pain in September of 2008. He was shown Dr. Eaton's record from September 23, 2008, and conceded the record indicated complaints of right low back and right leg pain, but he testified he recalled his pain being on the left side at that time.

Petitioner also agreed that he underwent chiropractic treatment from February of 2007 until September of 2007. He believed during that time he underwent 28 chiropractic treatments. He also agreed that in September and October of 2008 he underwent seven (7) chiropractic treatments.

On further cross-examination, and contrary to his testimony on direct examination, Petitioner indicated that his treatment in March of 2010 was due to a work accident. He did agree that his complaints in March of 2010 were on his right side. He added, however, that his right-sided complaints began in December of 2010. Petitioner then testified that he didn't remember seeing a chiropractor in March of 2010 as he did not see one until 2011.

Petitioner was shown Dr. Eaton's visits from March of 2010. Petitioner testified that he did not see the doctor at that time. He further testified that there is another "Steve Fred" in DuQuoin and "that was not me." He did agree that he saw Dr. Eaton in October of 2008.

Petitioner testified that Dr. Cochran referred him to Dr. Hayward. When asked about Dr. Hayward's note indicating he was referred by Dr. Furry, Petitioner testified Dr. Furry was his family doctor, but that Dr. Cochran had actually referred him.

Petitioner reiterated that his symptoms began after the two incidents at Alongi's and Goldman's house despite the notation in Dr. Hayward's records that his symptoms began in January of 2011. He testified he did not review Dr. Hayward's records prior to arbitration.

Petitioner reiterated on cross-examination that he told Dr. Hayward's PA Christopher Hodges about his two December of 2010 work accidents despite them not being documented in the initial treatment record of February 23, 2011. He further testified that he may have told the doctor it began in January of 2011 but it really started in December of 2010.

Petitioner testified he was seen at Southern Illinois Pain Management on March 2, 2011. He confirmed the note from this visit stated his symptoms began after awakening from sleep on January 12, 2011 with no new injury, but he testified his symptoms began in December despite what was documented in this record. Petitioner testified the Southern Illinois Pain Management record from March 2, 2011 does not accurately describe what had happened to him.

Petitioner denied that his low back condition simply gradually got worse over time while working for Respondent. He testified that "when something hits you like that and takes you almost to your knees, you know that's when it happened." Petitioner testified he was one of the strongest men who ever worked for Respondent, but following the two incidents in December of 2010, he could not perform his duties anymore.

Petitioner agreed there was no incident or accident that occurred in January of 2011. Petitioner testified that on January 10, 2011 his pain got so bad that he could no longer stand it and could no longer even drive. He again related that pain to the two incidents in December of 2010.

Petitioner testified he saw Dr. Hayward for the last time on June 22, 2012 after he had his lumbar x-ray made. Dr. Hayward's note indicated he would most likely release Petitioner from care after a one-year follow up. Petitioner did not follow up in 2013 with Dr. Hayward because he could not afford it, as his group health insurance had been cancelled.

Petitioner testified he saw Dr. Vaught on the advice of his attorney. Dr. Vaught did not render any treatment, but examined him, and advised him to apply ice every 20 minutes. He saw Dr. Vaught once.

Petitioner testified he has not sought work since retiring in 2016, when he turned 66 and began receiving Social Security benefits. Prior to that, he had received social security disability benefits, but was not a Medicare recipient.

Petitioner testified it was not accurate to say his low back pain developed in 2007 and continued until he quit working in January of 2011. He testified his prior low back pain resolved in 2008.

Petitioner testified he first saw chiropractor Dr. Eaton in 2002 for what he believed to be a shoulder issue. He treated with Dr. Eaton beginning in February of 2007 for a low back condition, during which time he continued to show up to work. He lost no time.

Petitioner testified that at the end of his treatment with Dr. Eaton in 2007, he was released to work full duty with no restrictions. He also testified that his back pain was "completely gone" after 2008. He then did not seek any further treatment until January of 2011.

On further cross-examination Petitioner agreed that he saw Dr. Eaton in for several months in 2007 for left-sided back pain. During that time he continued to work or, as he described it "showed up.' He did not lose any time from work. He was released with no restrictions in 2007.

Petitioner further testified that after another incident he returned to Dr. Eaton in September of 2008. Petitioner again treated with Dr. Eaton approximately seven (7) times from September to October, 2008 for left-sided back pain. After those seven visits, Petitioner quit going to Dr. Eaton because he felt good enough to work full duty without restrictions. He returned to his full duty work at that time. He lost no time following the 2008 work accident.

Petitioner further testified that he had no back problems from October of 2008 until his two work accidents in December of 2010 and his symptoms following those work accidents were right-sided.

On redirect examination Petitioner confirmed that he reviewed the work tickets from December 1, 2010 to January 11, 2011. (RX7) He testified that his initials on a work ticket did not mean that he physically loaded and unloaded materials. He was responsible for making sure the materials on the ticket were delivered. After he was injured on December 3, 2010, he testified that even Mr. Zoller told customers they would be required to unload the materials themselves, and Mr. Zoller had other employees load the materials for Petitioner; however, he could still drive at that point.

Petitioner testified that, assuming he underwent chiropractic treatment in March of 2010, approximately nine months prior to December of 2010, he received no other treatment after March of 2010. He saw no chiropractor, physician, surgeon, or any other medical professional from March of 2010 until after his work accidents at Alongi's and Carl Goldman's house.

Petitioner testified he knew for certain he was injured at Alongi's on December 3, 2010, and at Carl Goldman's house on December 23, 2010. He denied simply picking two dates.

Petitioner was shown an Application for Adjustment of Claim with a date of accident of "December 2010." (RX1; see also AX2). Petitioner testified he could not remember the exact

date of this injury until he reviewed the work order tickets. He knew it had been in the month of December.

Petitioner admitted filing other Applications for Adjustment of Claim claiming dates of accident of December 1, 2010, December 7, 2010, January 4, 2011, January 12, 2011, and March 2, 2011. Petitioner testified these were filed before he reviewed the work order tickets.

Petitioner testified that the Application for Adjustment of Claim for Case No. 12-WC-26843, on which the date of accident was amended to December 3, 2010, described an incident lifting sheet rock and roofing shingles to customer Alongi's Restaurant in the regular course of employment. Petitioner testified he had always been able to identify Alongi's Restaurant as the location where he was injured. The work ticket from December 3, 2010 described the same delivery to Alongi's as was described in his Application for Adjustment of Claim. (PX 10)

Petitioner was also shown an Application for Adjustment of Claim with a date of accident December 7, 2010. Petitioner testified that the location of the accident contained in this Application for Adjustment of Claim was Carl Goldman's house. (RX1)

Petitioner testified it was "fair to say" he knew he had been injured at Alongi's and at Goldman's house even prior to reviewing the work tickets. The work order tickets for Alongi's on December 3, 2010, and for Carl Goldman on December 23, 2010, confirmed the actual dates for Petitioner. (PX10; PX11)

Petitioner was asked why he filed so many Applications for Adjustment of Claim if he knew he had been injured at Alongi's and at Goldman's house. Petitioner testified he did not know, and that perhaps it was because his attorney told him to. Regardless, Petitioner testified that once he got the work order tickets, he knew exactly when he had been injured. He always knew where, but the work tickets confirmed when.

The Arbitrator concludes:

Petitioner's Credibility.

At the outset the Arbitrator notes that, initially, Bruce Zoller's absence was troubling given Petitioner's testimony as to comments by him as well as his alleged business practices regarding the handling of work injuries. However, as she reviewed the record and the testimony of Petitioner this became less of a concern as she determined that Petitioner, himself, was not a credible witness and his testimony about Mr. Zoller may have been largely self-serving given the disputed issues of accident and notice in all four of his claims. Furthermore, the take-away from Petitioner's testimony was the suggestion that he didn't want to mention a work accident to any doctors so that his group health would cover the costs per Mr. Zoller's "wishes." However, Petitioner had been working for Respondent for seventeen years. He had mentioned work accident in prior visits (2002 and 2008) and he had told Dr. Sowerby about gradually developing work-related problems.

There were other inconsistencies in, not only Petitioner's testimony on direct examination and cross-examination but between his testimony and what is found in the medical records.

Petitioner testified that he had no right-sided back/leg complaints in September of 2008. Dr. Eaton's records show otherwise. Petitioner acknowledged having some low back treatment in March of 2010 and some right-sided complaints during that time but further claimed they were unrelated to any work accident. He then testified to the contrary on cross-examination as he denied any treatment in March of 2010 whatsoever and further claimed there was another person with the same name as his living in DuQuoin who must have had that treatment; however, no steps were taken to clarify this by affidavit or deposition of the doctor. Furthermore, it seems strange that, if Petitioner didn't treat in March of 2010 as shown by the records, why was Dr. Vaught asked to assume that he did? There was also Dr. Eaton's note of 2011 in which he stated he had last seen Petitioner in March of 2010. Finally, there was Dr. Wittenauer's reference in January of 2011 to having last seen Petitioner in March of 2010. Thus, two of Petitioner's treating doctors acknowledged treating Petitioner in March of 2010 contrary to Petitioner's testimony.

Petitioner presented to Wittenauer Chiropractic on January 13, 2011 with a "new problem" that the doctor attributed to an onset date of December 30, 2010. The doctor also noted that his diagnosis from December 30,2010 needed to be amended. Petitioner, on cross-examination, was asked about the history and testified it was wrong and that someone must have written it down wrong. Petitioner knew accident was in dispute with regard to his claims and, yet, he undertook no effort prior to arbitration to correct a possible scrivener's error or otherwise address what he felt was a mistake. His explanation for the history wasn't persuasive.

A review of Dr. Sowerby's March of 2011 report shows that Petitioner told the doctor he had noticed gradually increasing back pain with the work he had been doing over the years as a delivery person. (RX 6) However, at the hearing Petitioner denied any gradual pain stemming from work duties and he voluntarily dismissed his claims based upon repetitive trauma thereby seeming to contradict any history provided to Dr. Sowerby. Again, another inconsistency.

Another major inconsistency stems from Petitioner's testimony regarding his level of activity at work after the alleged December 3, 2010 accident. Petitioner testified that after his alleged December 3, 2010 accident he was unable to work full duty for Respondent (ie. lift and carry) as his symptoms weren't going away so he worked "modified duty." He testified that he then had another accident on December 23, 2010 while carrying sheet rock out of Carl Goldman's home. On cross-examination Petitioner was asked if he actually worked after December 3rd and he replied that he mostly sat around "because he could do very little." Petitioner also denied making any deliveries after December 3rd but then acknowledged making some deliveries because "he guessed his inflammation had lessened." Petitioner was also asked about a number of delivery tickets bearing his initials. He testified that he only drove the delivery truck and that others loaded and unloaded because he was unable to do so. Petitioner further testified that he only sat around at work or drove the delivery truck and others loaded and unloaded because he was unable to do so. If Petitioner is to be believed regarding his inability to physically do anything for Respondent after December 3, 2010 then his testimony about sustaining another accident on December 23, 2010 is untrue as, by his own testimony, he

couldn't have been carrying anything at Carl Goldman's home. Alternatively, if his testimony about his level of activity was not true then he continued to work full duty making deliveries. Either way, Petitioner's believability has been undermined.

Yet another credibility issue surfaced regarding Petitioner's testimony regarding his referral to Dr. Hayward. Petitioner testified that Dr. Cochran referred him to Dr. Hayward. That is not corroborated by Dr. Cochran's records. Furthermore, Dr. Hayward's records indicate "Dr. Furry" (Petitioner's family doctor – see p. 20 of PX 3) was the referring physician (and Dr. Furry received copies of all office notes from Dr. Hayward). Petitioner provided absolutely no testimony as to why Dr. Furry referred him to Dr. Hayward (since he claimed Dr. Cochran did so). Additionally, Dr. Furry's records aren't a part of the record which is troubling since it is clear from Dr. Hayward's records that the referral to a spine surgeon came from him.

Petitioner went into the arbitration hearing knowing that "accident" was an issue in each of his four cases that were going forward. With regard to the alleged accident dates in December of 2010, it wasn't just the date of accident being disputed but also the mechanisms of injury and lack of any real corroboration for either alleged date of accident in Petitioner's treating medical records. Petitioner testified that on December 3, 2010 he was delivering sheet rock to Alongi's restaurant. He testified that he was injured while lifting street rock and that two other people were working with him when it happened (one of which was an employee of Alongi's). Petitioner could have subpoenaed these people or obtained affidavits from them to corroborate his testimony. He didn't and he provided no explanation as to why he couldn't or didn't.

Similarly, Petitioner testified that he wasn't sure if he told Wittenauer Chiropractic about his December 3, 2010 accident. He also testified that he told Dr. Cochran he injured himself at work and that he told Dr. Hayward's PA-C Chris Hodges about hurting his back at work. None of the records of these treaters corroborates Petitioner's testimony. Again, Petitioner could have deposed them to obtain corroboration; however, he didn't.

Further credibility issues come to light upon reviewing Dr. Vaught's consultation exam. Dr. Vaught's report references that Petitioner told him he was unable to return to work for Respondent due to work restrictions recommended by Dr. Hayward. This is untrue as Dr. Hayward's office notes and records fail to mention any permanent restrictions or recommendations. It also appears that Petitioner never advised Dr. Vaught that he never returned to Dr. Hayward for a final release. Petitioner testified that Dr. Vaught recommended he use ice every twenty minutes. There is no corroboration for that within Dr. Vaught's report or deposition. Petitioner's misrepresentations undermine his credibility.

Lastly, the Arbitrator found Petitioner's testimony about his current abilities difficult to believe and contrary to the objective reports and records in evidence. Petitioner's voiced complaints and limitations at trial essentially mirrored those of the permanent restrictions imposed by Petitioner's examining physician, Dr. Vaught. In comparison is the fact Dr. Hayward, when last seeing Petitioner after his surgery, noted Petitioner was doing "extremely well" with tolerable pain complaints at most. He required no medication. Petitioner was to follow up with Dr. Hayward but didn't. There was a gap of three years between Petitioner's last visit with Dr. Hayward and his examination with Dr. Vaught. When examined by Dr. Vaught,

Petitioner's physical examination was recorded as normal with only subjective complaints being noted. Dr. Vaught provided no reason as to why the permanent restrictions were necessary. He was, based upon Petitioner's history to him, erroneously under the impression Dr. Hayward had recommended permanent restrictions. There was no corroboration by any credible objective evidence for Petitioner's testimony regarding any current limitations and difficulties.

Issue C - Did an accident occur on February 23, 2007 that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner failed to prove that he sustained an accident on February 23, 2007 that arose out of and in the course of his employment with Respondent.

It is axiomatic that an injury is accidental under the Illinois Workers' Compensation Act when the injury can be traced to a definite time, place, and cause and occurs in the course of one's employment. Petitioner is claiming a specific accident in this case, as opposed to repetitive trauma. Therefore, Petitioner bears the burden of proving he sustained an accident on a specific date, time, and location. Petitioner herein failed to meet that burden of proof.

Petitioner testified to sustaining an accident in "February of 2007." He never testified to a specific date in February of 2007 when he allegedly hurt himself. He explained that he was pulling material out of a bin to load it on the truck and he heard "something" in his back. He thought he was pulling 2 x 8s, 2 x 10s, or 2 x12s. When asked what part of his body was affected, he replied that he didn't know for sure but he "knew" it was the lower part of his back. Petitioner never identified a specific date in February of 2007 when this accident occurred. When he presented to Dr. Eaton on February 26, 2007 (the first recorded visit of any medical treatment in February of 2007) Dr. Eaton did not note a specific date of accident in his history. Petitioner continued to treat with Dr. Eaton for several months with no mention of a specific work accident in February of 2007 ever being recorded.

The first indication of any accident occurring on February 23, 2007 presented itself at the time of trial when Petitioner amended his claim herein to allege that date. Until then Petitioner was alleging an accident date of "February 2007." That claim, not filed until August 6, 2012 also alleged the accident was caused by loading and unloading sheet rock and roofing shingles. According to Petitioner's testimony he injured his back pulling 2 x 8s or 2x 10s out of a truck. He didn't mention any shingles or sheet rock in his testimony.

The Arbitrator has considered Dr. Eaton's letter stating that Mr. Zoller paid for Petitioner's chiropractic care. However, payment of medical bills is not an admission of liability. While it might suggest a conversation with Mr. Zoller about needing medical care occurred, it did not establish that Petitioner sustained an accident on February 23, 2007 while pulling wood out of a truck.

In summary, Petitioner's testimony as to when the accident occurred lacked sufficient detail and, furthermore, his testimony as to an alleged accident was not corroborated by any medical records. Given Petitioner's lack of credibility, combined with the foregoing, Petitioner failed to prove he sustained an accident on February 23, 2007 which arose out of and in the

course of his employment. Petitioner's claim for compensation is denied and no benefits are awarded.

Issue "E" - Was timely notice of accident given to Respondent?

Petitioner failed to provide Respondent with proper notice of an accident as required under the Act. Petitioner's testimony regarding his conversation with Bruce Zoller after the alleged accident was vague. Petitioner testified that he told Mr. Zoller "he couldn't take it anymore." Petitioner did not testify that on a specific date he told Mr. Zoller about having a work accident on February 23, 2007 while pulling wood out of a truck.

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

Even assuming, arguendo, that Petitioner sustained an accident on February 23, 2007, Petitioner failed to prove that his current condition of ill-being is causally related to that injury.

No doctor opined that Petitioner's current condition of ill-being in his low back was caused, in whole or part, by the alleged accident of February 23, 2007. Since February 23, 2007 Petitioner has alleged additional accidents to his low back which are the subject of other claims. Petitioner treated with Dr. Eaton from February 26, 2007 through September 7, 2007. Thereafter, he underwent no treatment for his low back until September 23, 2008, approximately one year after last seeing Dr. Eaton. Dr. Eaton's records from September 23, 2008 contain no reference to or mention of a February 23, 2008 accident. Furthermore, Petitioner testified that he had no further low back complaints after September 7, 2007 until an alleged accident in "September of 2008", which is the subject of a different claim. Finally, the Arbitrator notes Petitioner's testimony wherein he clearly indicated that his prior back pain in 2007 and 2008 (which he did not associate with the February 23, 2007 incident) resolved and was "completely gone."

Petitioner failed to prove that his current condition of ill-being in his low back is causally related to his alleged accident of February 23, 2007. Petitioner claim for compensation is denied.

Issue "L"—What is the nature and extent of the injury?

Given the Arbitrator's determinations regarding accident, notice, and causation as set forth herein, this issue is rendered moot.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAUL FRED,

Petitioner,

vs.

NO: 13 WC 10760

DUQUOIN HOME LUMBER ,

18IWCC0359

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, and permanent partial disability (PPD), and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

For reasons stated in Decision 13 WC 10931, the Commission finds the Petitioner credible. The Commission otherwise affirms and adopts all else.

IT IS THEREFORE ORDERED BY THE COMMISSION, that the Decision of the Arbitrator filed August 17, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

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

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

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

18IWCC0359

party commencing the 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 - 2018

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 4/16/18
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FRED, PAUL S
Employee/Petitioner

Case# **13WC010760**

12WC026843
13WC010931
12WC026857

DuQUOIN HOME LUMBER
Employer/Respondent

18IWCC0359

On 8/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

0693 FEIRICH MAGER GREEN RYAN
D BRIAN SMITH
PO BOX 1570
CARBONDALE, IL 62903

1454 THOMAS & ASSOCIATES
ROBERT HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

18IWCC0359

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

Paul S. Fred
Employee/Petitioner

v.

DuQuoin Home Lumber
Employer/Respondent

Case # **13 WC 010760**

Consolidated cases: 12 WC 26843, 13 WC 10931, 12 WC 26857

An *Application for Adjustment 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 **June 13, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS 18IWCC0359

On **September 2, 2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident *was 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 **$21,621.60**; the average weekly wage was **$415.80**.

On the date of accident, Petitioner was **58** years of age, *married* with 0 dependent children.

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

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

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

Respondent is entitled to a general credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on September 2, 2008 that arose out of and in the course of his employment for Respondent, that timely notice of his alleged accident was given, or that his current condition of ill-being is causally connected to his alleged accident of September 2, 2008. 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

August 12, 2017
Date

AUG 17 2017

Paul S. Fred v. Du Quoin Home Lumber, 13-WC-10760

Findings of Fact and Conclusions of Law

Petitioner originally had eight claims pending against Respondent. Four of these claims were dismissed at the time of arbitration. The remaining four cases went to arbitration with the parties understanding that separate decisions would issue for each claim. Petitioner alleges an accident date of September 2, 2008 in this claim.

The Arbitrator finds:

Petitioner's medical records date back to 2002. On December 4, 2002, Petitioner was seen at DuQuoin Chiropractic Center. Petitioner's Patient Information Form references an injury date of December 2, 2002 which was job-related. (PX 4; RX 3) Petitioner was complaining of neck stiffness and headaches. A history of having been bucked off a horse and left shoulder complaints stemming from "extensive overuse of the left arm" was noted. According to the note, "this all happened about a year ago." Dr. Eaton also noted that Petitioner had occasional back pain described as "crampyness [sic]." (PX 4; RX 3)

Petitioner continued to see Dr. Eaton on six occasions in December of 2002 regarding his left shoulder, left index finger, and mid-back. (PX 4; RX 3)

Petitioner returned to see Dr. Eaton on February 26, 2007, having last been seen there in December of 2002. Petitioner was very sore in the L4-S1 levels and was having difficulty walking, with his symptoms in his low back having been steadily getting worse for the preceding 3 – 4 days. Petitioner continued to see Dr. Eaton in February and March of 2007. Dr. Eaton noted Petitioner's need to periodically sit at work every hour or so and then the pain would stop. Petitioner was also noted to be doing housework and riding his horse, although not very fast. On March 28, 2007 Dr. Eaton noted that Petitioner had been very sore the day before after moving some shingles. (PX 4; RX 3)

Petitioner continued to see Dr. Eaton in April and May of 2007. (PX 4; RX 3) On May 11, 2007, Petitioner reported he was steadily improving and had been very active the previous week. On May 18, 2007, Petitioner reported he was continuing to improve, and that he was performing nearly his normal work duties with only a dull ache. On May 25, 2007, Petitioner reported doing his normal work, which included moving shingles and sheetrock, with very little difficulty.

Petitioner was seen by Dr. Eaton three (3) times in June of 2007 reporting only minimal symptoms consisting of a dull ache on June 1, 8, 22, and July 6, 2007. On July 6th Petitioner reported doing very well and working long days with lots of heavy lifting and experiencing only a dull ache rather than any sharp pain. (PX 4 at 6, RX 3)

On July 16, 2007, Petitioner reported to Dr. Eaton that his low back was very painful after performing heavy lifting. (PX4 at 5). He also reported bilateral leg pain on this date.

Petitioner was seen on July 17, 20, and 24, 2007, complaining of a painful low back. On the 20th he associated his pain with lifting his granddaughter. (PX 4; RX 3)

By July 27, 2007, Dr. Eaton noted Petitioner was doing much better. (PX4 at 5). On August 10, 2007, Petitioner reported only occasional dull aching with no sharp pain despite working very hard at work performing lots of lifting. (PX 4; RX 3)

On September 7, 2007, Petitioner returned to see Dr. Eaton reporting that he was doing very well with only occasional dull aching and no sharp pain. (PX 4; RX 3)

Petitioner was not seen again by Dr. Eaton until September 23, 2008, more than a year following his last visit. (PX4 at 5). Dr. Eaton's note described low back pain beginning approximately three weeks earlier on the left after moving 2x8s at work. He stated the pain dissipated two or three days thereafter with the use of ice, but had returned approximately two weeks earlier to the visit, and included right-sided dull pain radiating to the front side of his leg to his knee. (PX 4; RX 3)

Thereafter Petitioner continued his chiropractic treatment with Dr. Eaton with an additional two visits in September of 2008 and four (4) visits in October of 2008. (PX4 at 4-5; RX 3) As of September 29, 2008, Petitioner felt 90 percent better with an occasional sharp pain when "twisting wrong." During the October visits, Petitioner reported only dull aching or intermittent sharp pain following walking and lifting.

Petitioner returned to see Dr. Eaton on March 8, 2010, having last been seen in October of 2008. Dr. Eaton noted Petitioner had very severe lower back pain and left sacroiliac joint pain. He was having difficulty walking but denied any radiating pain. On March 9, 2010 Dr. Eaton noted no significant change in Petitioner's condition. He still had difficulty walking and sleeping. Dr. Eaton wrote, "He has steadily been getting worse for about 3 weeks but no specific injury to cause it." (RX 4)

Records from Wittenauer Chiropractic, located in Pinckneyville, Illinois, indicate that Petitioner was seen one (1) time for chiropractic treatment on March 30, 2010. (PX5 at 4[1]) According to a general information sheet, Petitioner was there due to neck and back pain. He gave an onset date of "three weeks ago." (RX 4) He denied that the condition was getting worse but indicated that it interfered with his work, sleep, and daily routines. In response to the question "Have you had this or similar conditions in the past?" Petitioner marked "Yes" and noted "Just lower back." (RX 4) When seen by the doctor, Petitioner complained of left sacroiliac and left lower back pain, rating both at 6 out of 10. When asked what aggravated his problem, he responded "it is when he bends and lifts too much." Petitioner also reported that his problems became better when he used NSAIDs and rested. (PX 5 at 4) Petitioner was moderately tender over his left sacroiliac articulation. In the prone position, a functionally short right leg length was noted. An onset date of February 28, 2010 was also noted. (RX 4)

[1] See also RX 4, a copy of Wittenaur Chiropractic records.

According to Respondent's delivery records, on December 1, 2010 Petitioner made deliveries to the old Baptist Church, Searby Funeral Home, DQ High School, and Dave Kent. (RX 7)

According to Respondent's delivery records, on December 2, 2010 Petitioner made deliveries to Jackie Davision, Terry Marks, Brad Galli, John Tilley, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 3, 2010 Petitioner made deliveries to Steve Eisenhauer, McPherson Auto, and Terry Marks (Job – Alongi's). (RX 7; PX 10)

According to Respondent's delivery records, on December 4, 2010 Petitioner made deliveries to Doug Hill, Steve Epplin, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 6, 2010 Petitioner made a delivery to Eric W. (RX 7)

According to Respondent's delivery records, on December 7, 2010 Petitioner made deliveries to Carl Goldman and Dave Kent. (RX 7)

According to Respondent's delivery records, on December 8, 2010, Petitioner made deliveries to Kenny Heape and Pete Daumond. (RX 7)

According to Respondent's delivery records, on December 9, 2010 Petitioner made deliveries to Terry Marks, Gary Dickerson, Joel Tolliver, Steve Eisenhauer, P.C.H.A., Gerald Weeks, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 10, 2010 Petitioner made deliveries to Chris Albers, Steve Eisenhauer, Pinckneyville High School, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 13, 2010 Petitioner made a delivery to Tom Denton. (RX 7)

According to Respondent's delivery records, on December 14, 2010 Petitioner made a delivery to Steve Eisenhauer. (RX 7)

According to Respondent's delivery records, on December 15, 2010 Petitioner made deliveries to Carl Goldman and Absolute Construction. (RX 7)

According to Respondent's delivery records, on December 16, 2010 Petitioner made two deliveries to Jackie Davision. (RX 7)

According to Respondent's delivery records, on December 17, 2010 Petitioner made a delivery to Matt Milam, the Elks Club, and Ron Davis. (RX 7)

According to Respondent's delivery records, on December 20, 2010 Petitioner made a delivery to Gene Creek, Chase Porter and Dave Kent. (RX 7)

According to Respondent's delivery records, on December 21, 2010 Petitioner made a delivery to Monte Kuhnert, Carl Goldman, Chase Porter, and Taylor Brothers. (RX 7)

According to Respondent's delivery records, on December 22, 2010 Petitioner made a delivery to "5 - Star." (RX 7)

According to Respondent's delivery records, on December 23, 2010 Petitioner made a delivery to Carl Goldman. (PX 11)

According to Respondent's delivery records, on January 4, 2011 Petitioner made a delivery to Amanda Dearmond, Mark Roznowki, and Graham's Painting. (RX 7)

According to Respondent's delivery records, on January 11, 2011 Petitioner made a delivery to Kellerman's Powder Coat. (RX 7)

On January 13, 2011 Petitioner returned to Wittenauer Chiropractic, having last been seen in March of 2010 and described a "new problem" of right-sided sacroiliac and sciatic pain that he rated at 10 out of 10. Dr. Wittenauer also wrote "The patient's diagnosis from Thursday, December 30, 2010, was amended today." The note also contains a date of onset of December 30, 2010. When asked what made the problem worse, Petitioner responded that "it's worse when he does nothing in particular because it is always there." Petitioner also reported that nothing was relieving his problems. (PX 5; RX 4)

On January 14, 2011, Petitioner returned to Wittenauer Clinic, reporting that he was doing better but also complaining of 9 out of 10 right sacroiliac and right sciatic pain. He underwent chiropractic treatment on that date. Petitioner was advised to return as needed. (PX 5 at 2)

On January 26, 2011, Petitioner was seen by Dr. Douglas Cochran, Tri-County Chiropractic Centre, in Du Quoin, Illinois. (PX3 at 17) Petitioner completed a "New Patient Case History" form. He indicated that his chief complaint was right-sided back pain and pain down his right leg. He claimed his injuries were due to an on-the-job injury but he left the date of accident blank and stated that he didn't intend to turn it in to workers' compensation. (PX 3 at 19) Dr. Cochran noted that Petitioner had been experiencing severe lower back pain and right lower extremity pain for several weeks and had been unable to work for the past two weeks due to his pain. Petitioner stated he first noticed his pain after lifting drywall and that this had happened before but was getting worse. His pain was located in his L3 to S1 region, as well as his right upper anterior thigh. He rated his pain at 8-9 out of 10. Dr. Cochran suspected a lumbar discopathy based upon lumbar x-rays which revealed mild degenerative changes throughout Petitioner's lumbar spine. His physical exam yielded a positive straight leg raise test on the right, positive Lasegue's and Braggard's tests on the right, and right quadriceps weakness. (PX3 at 18) Dr. Cochran assessed Petitioner with lumbar discopathy on this date, which he characterized as a "new condition." (PX3 at 15)

Petitioner returned to Dr. Cochran for four (4) chiropractic treatments in January and February of 2011, before Dr. Cochran referred Petitioner for an MRI of his lumbar spine. (PX3 at 2-14) Petitioner did not return to Dr. Cochran following his MRI. (PX3).

On February 8, 2011, Petitioner underwent a lumbar MRI at Cedar Court Imaging, in Carbondale, Illinois. (PX 3; PX6) The MRI revealed a disc protrusion or mild herniation at L2-3 in the right paracentral region of the spinal canal extending toward the right foramine, resulting in moderate to severe spinal stenosis and right foraminal stenosis. (PX6 at 2) There was asymmetric disc bulging at L3-4 toward the right. At L4-5, there was moderate to prominent left facet arthropathy indenting and compressing the left lateral and left posterolateral aspects of the thecal sac. At L5-S1, there was asymmetric bulging of the disc centrally and posterolaterally toward the left extending into the inferior left foramine. Summarily, Petitioner had evidence of multilevel disc disease with areas of spinal stenosis and foraminal stenosis as noted in the findings.

On February 23, 2011, Petitioner was seen by a physician's assistant at the office of neurosurgeon Dr. Franklin Hayward, Heartland Spine, Marion, Illinois. (PX9 at 25[2]) Petitioner had been referred by Dr. Furry for his lower back, right hip, and leg pain. According to the note "This started in January 2011." Petitioner had tried conservative treatment but had not experienced any relief. Dr. Hayward's note documented decreased range of motion, paralumbar tenderness, sciatic nerve tenderness on the right, and positive straight leg testing on the right. (PX9 at 25) Dr. Hayward's note also noted decreased sensation in the S1 distribution. Per the MRI, Petitioner was felt to have a disc protrusion asymmetric towards the left along with multilevel disc bulging and degeneration. He noted a disc protrusion at L5-S1 touching the exiting nerve root, and assessed Petitioner with right L5-S1 radiculopathy. He referred Petitioner for an epidural steroid injection.

On March 2, 2011, Petitioner was seen at Southern Illinois Pain Management, in Marion, Illinois, by Dr. Julie Sowerby. (PX8 at 8-11; RX 6) Petitioner described his problem as right leg numbness and aching, right foot burning, aching, and numbness and chronic burning and stabbing pain in his lumbar region and right buttock. Petitioner described the aggravating factors as sleep/rest, sitting and walking. In the narrative portion of the report, the doctor stated:

> [Petitioner] has a quite physical job working for a lumber yard. He reports that he has noticed gradually increasing back pain with the work that he does over a number of years. He states that he is a delivery person, and has to lift and move packets of shingles, which are quite heavy. He reports that his back pain began upon awakening from sleep on January 12, 2011. He did not have any new injury or trauma at that time. He does note difficulty performing his job duties due to his low back and leg pain. .....He states that prior to this morning in January when he awakened with pain, he did not have the leg symptoms that he currently has. … (RX 6)

[2] See also RX 5.

Dr. Sowerby noted Petitioner had difficulty with driving, leisure activities, sleeping, standing, walking, working, yard work, lifting and driving a car. Petitioner was diagnosed with facet arthropathy (spondylosis), without myelopathy, low back pain, lumbar degenerative disc disease and spinal stenosis. He was scheduled for an epidural steroid injection. He was also told to continue his Advil and she added Gabapentin. (PX8 at 10; RX 6).

Petitioner underwent an epidural steroid injection at L5-S1 on March 7, 2011, performed by Dr. Paul Juergens at Southern Illinois Pain Management. (PX8 at 7)

On March 22, 2011, Petitioner returned to Southern Illinois Pain Management reporting no relief from his pain, although he felt the numbness and tingling in his right foot was a little better. (PX8 at 5; RX 6)

On March 28, 2011, Petitioner underwent a second epidural steroid injection at L5-S1 slightly to the right of midline. (PX8 at 4)

On April 13, 2011, Petitioner returned to Southern Illinois Pain Management reporting a little relief following the injections, but also describing his condition as worsening. Petitioner told the PA that he would prefer to follow up with Dr. Hayward rather than undergo another injection. (PX8 at 2; RX 6)

On April 27, 2011, Petitioner returned to see Dr. Hayward's PA-C, Chris Hodges. (PX9 at 24) The note documented only temporary relief following injections. Petitioner was noted to have predominantly right lower extremity pain although some prior back pain in previous months had included the left lower extremity. Petitioner reported being unable to work due to discomfort. Petitioner still had sensory changes in the L5 distribution. Petitioner was not able to tolerate his symptoms, and wished to discuss surgical intervention with Dr. Hayward. (PX 9; RX 5)

On May 7, 2011, Petitioner was seen by Dr. Hayward. (PX9 at 23; RX 5) Petitioner's subjective complaints included continuing right leg pain, primarily below the calf and right foot, seemingly in the L5-S1 distribution. Dr. Hayward noted moderate to severe foraminal narrowing at L4-5 and L5-S1 on the left compressing the exiting nerve roots, and Petitioner's greatest areas of foraminal narrowing occurred at L2-3 and L4-5 on the right. Dr. Hayward referred Petitioner for a lumbar myelogram and post myelogram CT, and flexion/extension x-rays of the lumbar spine.

On May 18, 2011, Petitioner underwent a lumbar myelogram and post myelogram CT at Memorial Hospital of Carbondale. (PX7 at 26-27; 30-31) The lumbar CT revealed disc herniations at L2-3 and L3-4 lateralizing to the right, severe degenerative changes to the facet joints at L4-5, and a mild disc bulge at L4-5 as well as minimal anterolisthesis, and a disc bulge at L5-S1. (PX7 at 26-27) Lumbar x-rays from the same date confirmed the presence of spondylolisthesis at L4-5. (PX7 at 28)

On May 25, 2011, Petitioner returned to Dr. Hayward; however, due to a tornado warning, Dr. Hayward was unable to review Petitioner's CT myelogram. (PX9 at 16; RX 5). Dr. Hayward indicated his intent to speak with Petitioner later by telephone. Dr. Hayward noted that Petitioner was walking with an antalgic gait. He documented complaints of severe right leg pain with pain radiating into both the L4-5 and L5-S1 distributions. Dr. Hayward felt Petitioner would probably need a facetectomy with diskectomy, interbody spacer at L4-5, and L5-S1 with instrumentation and SSEP monitoring. (RX 5)

On May 27, 2011, Petitioner was again seen by Dr. Hayward. (PX9 at 15) Dr. Hayward noted the lumbar myelogram showed an L4-5 and L5-S1 right radiculopathy as well as low back pain related to his degeneration and facet arthropathy and neural foraminal stenosis. Petitioner was noted to have bilateral spondylitis at L4-5 and Grade 1 spondylolisthesis at L4-5. Dr. Hayward recommended a transforaminal lumbar interbody fusion at L4-5 and L5-S1 on the right, and decompression and discectomy at L2-3 and L3-4 on the right. Dr. Hayward wrote, "I feel that the patient's Grade 1 spondylolisthesis at L4-5 and disc desiccation at L4-5 and L5-S1 is causing his low back pain." He also noted that Petitioner had a combination of disc/osteophyte complex at multiple levels. Dr. Hayward chose not to perform a fusion at L2-3 and L3-4 due to the risk of adjacent segment disease although he noted a considerable amount of foraminal narrowing due to facet hypertrophy at those levels. (RX 5)

On June 23, 2011, Dr. Hayward performed transforaminal interbody fusions at L4-5 and L5-S1 on the right with laminectomy and discectomy at L3-4 on the right and a laminectomy at L2-3 on the right. (PX9 at 11)

On July 18, 2011 Dr. Eaton issued a note pertaining to Petitioner and his recent back surgery. Dr. Eaton indicated that he had last seen Petitioner on March 11, 2010 and had no knowledge as to his current condition. (PX 4)

On July 22, 2011, Petitioner returned to Dr. Hayward reporting dramatically improved leg and ankle pain. X-rays demonstrated excellent placement of the hardware and spacer. Dr. Hayward referred Petitioner for physical therapy. (PX 9 at 9)

In a note dated August 8, 2011, Dr. Eaton discussed payment of his bills, indicating that Bruce Zoller had paid a total of $600.00 for treatment Petitioner had received from "2-23-12[sic][3] thru 9-7-07." He also wrote that he had treated Petitioner seven times between September 23, 2008 and October 31, 2008 for which Bruce Zoller had paid $188.00. (PX 4)

On September 2, 2011, Petitioner returned to Dr. Hayward, who described Petitioner as "ecstatic" and very pleased with the outcome of his surgery. Petitioner was doing great. He wished to ride his horse but was told not to do so. (PX9 at 7) He was released to drive and instructed to wean out of his brace completely. Petitioner's leg pain was reportedly completely resolved, and Petitioner was no longer taking pain medication. Petitioner declined additional physical therapy and was told to return in twelve weeks for a CT scan.

[3] Should be 2/26/07

On November 14, 2011, Petitioner underwent a CT scan of his lumbar spine, without contrast, performed at Memorial Hospital of Carbondale. (PX7 at 9) The CT scan showed, *inter alia*, questionable spinal nerve root impingement that was not definitively excluded. (PX7 at 10)

On November 22, 2011, Petitioner was seen by Dr. Hayward, who reviewed the CT scan and stated it showed some evidence of bony growth particularly along the facet joints and around the screws, but there was some bone growth within the spacers that was not yet complete. Petitioner described his pain level as a "1" at most. He was noted to be doing extremely well. (PX9 at 4) Dr. Hayward recommended Petitioner return in six to eight months for a repeat CT scan. Dr. Hayward noted that as of January 1, 2012, Petitioner would not be able to afford any additional tests or procedures due to the high co-pay and Dr. Hayward stated he would settle on an x-ray.

On June 22, 2012, Petitioner returned to see Dr. Hayward. (PX9 at 3) Petitioner was reportedly doing extremely well. He had some pain complaints but described them as tolerable. He also reported some limitations with daily activities. X-rays demonstrated good placement of screws and alignment of the lumbar spine. Dr. Hayward recommended Petitioner follow up in one year with a CT scan and flexion/extension films of the lumbar spine, at which point Dr. Hayward stated he would most likely release Petitioner. Petitioner also requested a State of Illinois Disability Identification Card which the doctor signed, indicating Petitioner was at "Class 2." Petitioner did not return to Dr. Vaught's office following this visit. (PX9)

Petitioner has undergone no further medical treatment for his low back since June 22, 2012.

On August 6, 2012, Petitioner's Application for Adjustment of Claim in case #12 WC 26843 was filed. Petitioner alleged an accident date of December 1, 2010 when he was "lifting sheet rock and roofing shingles to customer, Alongi's Restaurant, in the regular course of employment." (AX 2, RX 1)

On August 6, 2012, Petitioner's Application for Adjustment of Claim in case # 12 WC 26857 was filed. Petitioner alleged an accident date of "February 2007" due to "loading and unloading of sheet rock and roofing shingles in the regular course of employment." (AX 4, RX 1)

On September 27, 2012 Petitioner's Application for Adjustment of Claim in case # 12 WC 33621 was filed. Petitioner alleged an accident date of March 1, 2011.[4] (IWCC website)

On September 27, 2012 Petitioner's Application for Adjustment of Claim in case # 12 WC 33656 was filed. Petitioner alleged an accident date of January 12, 2011 due to "repetitive trauma from loading and unloading of sheet rock and roofing shingles in the regular course of employment." (IWCC website; RX 1)

[4] RX 1 contains an unfiled/unnumbered Application for Adjustment of Claim with an accident date of "December 2010." This may be the same claim with injuries being attributed to "loading and unloading of sheet rock and roofing shingles."

On April 2, 2013 Petitioner's Application for Adjustment of Claim in this case (# 13 WC 10760) was filed. Petitioner alleged an accident date of September 2, 2008 while "lifting 2 X 8 pieces of lumber in the regular course of employment." (AX 6; RX 1)

On April 3, 2013 Petitioner's Application for Adjustment of Claim in case # 13 WC 10931 was filed. Petitioner alleged an accident date of January 4, 2011 due to "lifting in the regular course of employment." (AX 8; RX 1)

On April 3, 2013 Petitioner's Application for Adjustment of Claim in case # 13 WC 10922 was filed. Petitioner alleged an accident date of January 11, 2011 due to "repetitive trauma from loading and unloading building materials in the course of employment." (IWCC website; RX 1)

On April 3, 2013 Petitioner's Application for Adjustment of Claim in case # 13 WC 10928 was filed. Petitioner alleged an accident date of December 7, 2010 due to "repetitive trauma from loading and unloading of sheet rock and other building materials at the residence of customer, Carl Goldman, in the regular course of employment." (IWCC website; RX 1)

Report and Deposition of Dr. Vaught

By letter dated February 12, 2015 Petitioner's attorneys wrote to Dr. Kevin Vaught about the records review he had agreed to perform. The letter referenced all of Petitioner's pending accident dates. Counsel advised Dr. Vaught that it "was their belief" that Petitioner's symptoms were caused or aggravated by two separate incidents while Petitioner was working for Respondent in December of 2010 and/or January of 2011. According to the letter:

> The first injury occurred while [Petitioner] was picking up returned sheet rock from a customer's house. Six or seven sheets were returned. The sheet rock was four by twelve and 5/8 of an inch in width. Each sheet weighed approximately 100 pounds, and the package contained two sheets. [Petitioner] informed us he had to stoop to maneuver the sheet rock through the doorways of the house, and coming out of the house he felt a burning sensation in his low back.
>
> The second injury occurred when [Petitioner] was delivering the same size sheet rock to a restaurant in DuQuoin. [Petitioner] informed us as he was carrying a packet of the same size sheet rock referenced above in to the restaurant with another person. That other person adjusted his hands which twisted the sheet rock and placed greater weight on [Petitioner.] [Petitioner] stated he felt pain in his low back following this incident. (PX 2, Resp. Ex. 1, pp. 1-2)

Dr. Vaught was provided with a brief summary of Petitioner's treatment beginning on January 13, 2011 and advised of Petitioner's history of intermittent chiropractic care for his low back. Records pertaining to all of the foregoing were included. The doctor was further advised that "[b]ased on [Petitioner's] medical history as well as his expected testimony [Petitioner's attorneys] believed [his] low back and leg symptoms as first documented on January 13, 2011 in the records from Wittenauer Chiropractic were caused or aggravated by the incidents at work where [Petitioner] was lifting drywall in the weeks prior to January 13, 2011." (PX 2, Resp. Ex. 1, p. 3)

Petitioner was examined by neurosurgeon Dr. Vaught, Regional Brain & Spine, in Cape Girardeau, Missouri on April 6, 2015.

A written report of the visit followed on/about May 1, 2015. (PX1) In a letter dated May 1, 2015, FNP-BC Debra Alexander (associated with Regional Brain & Spine) issued a cover note regarding the request for an opinion letter on Petitioner. A summary of the consultation note was included. It was noted that Petitioner sought social security disability because he couldn't return to his heavy physical demand labor. Petitioner also denied the need for evaluation or treatment of any lower back symptoms at the time of the exam. Ms. Alexander further noted "My opinions are within a reasonable degree of medical certainty." (PX 1, p. 10)

The consultation note stated that Petitioner gave a history of an onset of symptoms following "two separate work injuries occurring on or about December of 2010 or January of 2011." (PX1 at 1) Both injuries involved carrying sheet rock. Dr. Vaught noted that the first incident involved carrying returned sheet rock out of an individual's home. (PX 1 at 1)

Petitioner described his initial symptoms following his two work accidents as stinging, burning and aching in his lower back, which progressively worsened. (PX1 at 1) He had not worked since January 10, 2011 due to his symptoms. He was treated operatively by Dr. Hayward, and his overall condition improved following lumbar surgery. Dr. Vaught was under the impression Petitioner was unable to return to his heavy physical demand occupation due to work restrictions that had been recommended by Dr. Hayward. (PX 1 at 1)

Dr. Vaught noted Petitioner's subjective complaints on April 6, 2015 included stinging, burning, and aching, which Petitioner modified with his activities. (PX1 at 1) He denied any post-operative complications, and stated he was pleased with his care both before and after surgery. His pain was rated as 1 out of 10.

Dr. Vaught documented normal motor, sensory, and reflex exams. (PX1 at 3) Range of motion of the lumbar spine was full, and straight leg raise tests were negative. (PX1 at 4)

Dr. Vaught reviewed Petitioner's February 8, 2011 lumbar MRI and stated it showed degenerative disc disease at L2-3 with a small central disc bulge and mild right foraminal narrowing; degenerative disc disease at L3-4 with a broad based disc bulge and a right herniated disc with moderate bilateral foraminal narrowing; degenerative disc disease at L4-5 with a broad based disc bulge and Grade 1 spondylolisthesis and moderate foraminal narrowing; and

degenerative disc disease with moderate foraminal narrowing at L5-S1.The worst foraminal narrowing was on the right at L4-5 and on the left at L5-S1. (PX1 at 4)

Dr. Vaught also reviewed Petitioner's myelogram and post-CT myelogram from May 18, 2011 and Petitioner's lumbar CT scan from November 14, 2011. The May 18, 2011 post-CT myelogram showed a right herniated disc at L2-3, a broad-based disc bulge at L3-4, Grade 1 degenerative spondylolisthesis at L4-5, and a herniated disc at L5-S1 with moderate to severe foraminal stenosis. (PX1 at 5)

Dr. Vaught opined Petitioner's low back and lower extremity symptoms were caused by Petitioner's work accidents. He reasoned that prior to his accidents, Petitioner was not seeking medical care for any active low back or leg problem and Petitioner's mechanism of injury was consistent with the pathology Dr. Vaught observed on Petitioner's diagnostic scans, and was consisted with Petitioner's pre-operative symptoms. (PX1 at 5-6) He felt, certainly, the lifting incidents described by Petitioner aggravated the pathology Dr. Vaught observed on Petitioner's imaging studies. (PX1 at 5). He related the need for Petitioner's treatment, including his lumbar surgery, to his work accidents. (PX1 at 8)

Dr. Vaught believed Petitioner was at maximum medical improvement (MMI) as it related to his work accidents. He placed a permanent 50 pound lifting restriction on Petitioner, with no repetitive bending, twisting or lifting, and no overhead work. (PX1 at 6)

Dr. Vaught was deposed on June 28, 2015. He is a board-certified neurosurgeon and independent medical examiner. (RX2 at 6) Dr. Vaught testified that he examined Petitioner on April 6, 2015 and reviewed his medical records around that same time. He prepared and signed a report containing his findings and conclusions. (RX2 at 7, see also RX1)

Dr. Vaught testified that Petitioner related two separate work accidents occurring in December of 2010 and early in January of 2011. Both involved carrying sheet rock. He testified that the first incident was while Petitioner was carrying sheet rock out of an individual's home and the second incident occurred while Petitioner was taking sheet rock off a forklift at a customer's home. (PX2 at 8) Following the incidents, Petitioner began developing stinging, burning, and aching in his low back, which progressively worsened. These symptoms never resolved on their own. (PX 2 at 9)

Dr. Vaught also testified that Petitioner told him he had experienced intermittent back problems prior to his work accidents. He had previously seen a chiropractor intermittently, but had not recently seen anyone for any actual problems prior to the two 2010 work accidents. (PX2 at 9) Dr. Vaught testified there was no record of any treatment or complaints of either low back or lower extremity pain after March 30, 2010. (PX2 at 23)

Dr. Vaught reviewed the January 13, 2011 note from Wittenauer Chiropractic. (PX2 at 10) Dr. Vaught also testified that the chiropractor noted an onset date of December 30, 2010. Dr. Vaught testified that such a history was consistent with the history provided to him by Petitioner. Petitioner's subjective complaints documented in that note were right sacroiliac articulation and right sciatica, both rated at 10 out of 10. (PX2 at 10) This was described as a new problem.

((PX2 at 10) The documented date of onset in the note was December 30, 2010, which was consistent with the timeframe given by Petitioner on April 6, 2015. (PX2 at 11)

Dr. Vaught also reviewed the March 30, 2010 note from Wittenauer Chiropractic, which was several months prior to the January 13, 2011 visit. (PX2 at 11-12) On that date, Petitioner described left, not right, sacroiliac articulation, and left, not right, lower back pain, and left neck pain. (PX2 at 12) He rated his pain at only 6 out of 10 on that date. (PX2 at 12)

Dr. Vaught further testified concerning his review of Petitioner's medical records from before the 2010 work accidents. (PX2 at 13, 22) According to him, none of those records documented either the type or the severity of the symptoms described in Petitioner's January 13, 2011 record from Wittenauer Chiropractic. (PX2 at 13) Dr. Vaught testified that Dr. Hayward's notation that Petitioner's symptoms began in January of 2011 was consistent with what Petitioner told him. (PX 2 at 16-17) He also testified that Petitioner did not relate to him waking up one morning with back pain (as referenced in the history given at SI Pain Management). (PX 2 at 18) Dr. Vaught felt that none of Petitioner's records from any other provider documented the same severity or type of symptoms as were documented on January 13, 2011. (PX2 at 22)

Dr. Vaught also reviewed Dr. Cochran's January 26, 2011 note. (PX2 at 13) Petitioner's visit was a little more than a week following Petitioner's visit to Wittenauer Chiropractic. (PX2 at 13) Dr. Cochran's note documented severe low back pain and right lower extremity pain for several weeks, which Petitioner first noticed after lifting drywall. (PX2 at 14-15) Dr. Vaught testified this history was consistent with the history given to him by Petitioner on April 6, 2015. (PX2 at 15)

Dr. Vaught reviewed Petitioner's February 8, 2011 lumbar MRI and testified his biggest issue was an L3-4 disc herniation on the right. (PX2 at 15) He also had Grade 1 spondylolisthesis at L4-5, and significant foraminal narrowing at L2-3, L3-4, L4-5, and L5-S1. (PX2 at 15) This pathology was consistent with Petitioner's subjective complaints of pain discussed in the January 13, 2011 record from Wittenauer Chiropractic, and Dr. Cochran's chiropractic records. (PX2 at 15)

Dr. Vaught also testified that the pathology he observed on the lumbar MRI was also consistent with the objective physical findings documented by Dr. Cochran on January 26, 2011. (PX2 at 15) Dr. Vaught testified that Dr. Cochran suspected a radicular problem, which based on the exam and history and MRI, showed findings correlating anatomically to the distribution Dr. Cochran suspected. (PX2 at 15-16)

Dr. Vaught testified that Dr. Hayward's initial treatment record documented Petitioner's symptoms beginning in January of 2011. (PX2 at 16) He felt this was consistent with the timeframe given to Dr. Vaught by Petitioner and Dr. Hayward's documented subjective complaints and objective physical findings were consistent with the pathology observed on the MRI. (PX2 at 16 - 17)

Dr. Vaught also reviewed the records from Southern Illinois Pain Management. (PX2 at 17) The March 2, 2011 note documented complaints of pain, numbness, and aching, as well as

right foot burning, aching, and numbness. (PX2 at 17-18) The note documented Petitioner describing his job duties for Respondent as quite a physical job. (PX2 at 18) Dr. Vaught testified the history of Petitioner's onset of symptoms contained in this note was consistent with what Petitioner told about the two acute events. (PX2 at 18)

According to Dr. Vaught, Petitioner underwent an L4-5 and L5-S1 transforaminal lumbar interbody fusion with instrumentation, then a right L3-4 microdiscectomy and medial facetectomy and foraminotomy, and a right L2-3 laminectomy and foraminotomy. (PX2 at 21) Petitioner did well following surgery. (PX2 at 21)

Dr. Vaught personally met with Petitioner and his wife on April 6, 2015. (PX2 at 25) He took a history from Petitioner and performed a physical exam. His opinions are his own. (PX2 at 25) Dr. Vaught's nurse practitioner, Debra Alexander, assisted with the examination and preparation of Dr. Vaught's report. (PX2 at 24) Dr. Vaught personally reviewed the medical records, and Ms. Alexander acted as a scribe. (PX2 at 24) She translated the handwritten patient form completed by Petitioner[5] into the electronic format, and assisted with obtaining the history from Petitioner. (PX2 at 24) Dr. Vaught routinely has Ms. Alexander assist in the transcription of reports; however, Dr. Vaught reviews all the reports prior to signing. (PX2 at 25)

Dr. Vaught testified that he felt Petitioner was at maximum medical improvement (MMI) and that he needed a permanent 50 pound lifting restriction, as well as restrictions on bending, twisting, and squatting. (PX2 at 25-26) Dr. Vaught causally related the need for these restrictions to Petitioner's work accidents. (PX2 at 28-29)

Dr. Vaught causally related Petitioner's low back and lower extremity symptoms to the two sheet rock lifting incidents Petitioner reported to him. (PX2 at 26) Dr. Vaught testified the disc herniation at L3-4 on the right "was a direct result of that work-related injury." (PX 2 at 27) 27) The degenerative changes were also aggravated, particularly the foraminal stenosis and spondylolisthesis. (PX2 at 27)

Dr. Vaught testified it was significant that Petitioner was not seeking medical care for an active low back or leg problem prior to his work accidents. (PX2 at 27) He also based his opinions on simply talking to Petitioner and hearing him relay the same history. (PX2 at 27) Further, Dr. Vaught based his opinions on the difference in the severity of Petitioner's pain prior to his work accidents and after. (PX2 at 27) The following exchange then occurred:

> Q. The mechanism of injury that [Petitioner] reported to you, was that consistent with causing or aggravating [his] pathology you previously testified to?
>
> A. Yes. Heaving lifting is one of – one of the causes of a herniated disc and aggravating back pain. He also testified that the mechanism of injury, lifting sheet rock, was consistent with a disc herniation and aggravation of preexisting degenerative lumbar conditions.

[5] Not a part of the record.

Dr. Vaught further testified that Petitioner's treatment, including surgery, was reasonable and necessary to relieve Petitioner of the symptoms the doctor believed were causally related to his work accidents and subsequent treatment. (PX2 at 28)

On cross-examination Dr. Vaught acknowledged that the majority of the records he reviewed were from December of 2010 and onward. He further testified that the records he reviewed pre-dating December of 2010 did not describe a severe radicular pain syndrome consistent with a herniated disc. (PX 2 at 30) Dr. Vaught described Petitioner's pre-December of 2010 complaints of intermittent back pain and sacroiliac joint discomfort as transient in nature. Dr. Vaught further testified that he was not provided with any indication of work accidents prior to December of 2010. Furthermore, he did not recall that the medical records he reviewed related or indicated any work accidents prior to December of 2010. (PX 2 at 31)

Dr. Vaught confirmed on further cross-examination that his causation opinions were related to alleged accidents in either December of 2010 or January of 2011. (PX 2 at 31)

On additional cross-examination Dr. Vaught acknowledged receiving a letter from Petitioner's attorney along with medical records to review. That letter was marked as RX 1 to the deposition. Dr. Vaught acknowledged that the history provided to him regarding Petitioner was contained in that letter and was the same history Petitioner provided to him. (PX 2 at 33-34)

Dr. Vaught agreed that there was no mention in Dr. Wittenauer's January 13, 2011 note of any incident wherein Petitioner's back was hurting after lifting drywall. (PX 2 at 34, 35) He agreed that Dr. Wittenauer's notes reference an onset date of December 30, 2010. (PX 2 at 35) Dr. Vaught also agreed that the doctor's notes from that visit state that nothing in particular aggravated Petitioner's problems because they were always there. (PX 2 at 36) Dr. Vaught agreed there was nothing in Dr. Wittenauer's January 1, 2011 note stating Petitioner hurt his back after lifting drywall. He also agreed that Dr. Hayward's record of February 23, 2011 states Petitioner's low back and right hip pain began in January of 2011. He agreed there was no mention in that office visit of an incident involving the lifting of drywall in December of 2010 or January of 2011. Dr. Vaught also agreed that the SI Pain Management record of March 2, 2011 contains a history wherein Petitioner indicated his back pain began when he woke up on January 12, 2011 and that there was no new injury or trauma. (PX 2 at 36-37)

Dr. Vaught testified that chronic pain is defined as pain in the same distribution or location that occurs for more than six months. He agreed that the DuQuoin Chiropractic records from 2007 indicate Petitioner was getting consistent treatment for severe low back pain for several months. He agreed that the April 6, 2007 entry, while hard to read, suggests Petitioner was having some pain after doing extensive lifting and that on May 25, 2007 he had back pain after moving shingles and sheetrock. He also agreed there are references to heavy lifting and back pain on July 16th and July 27th. Dr. Vaught also agreed that the September 23, 2008 entry states Petitioner was having low back pain that started three weeks earlier on the left after moving two by eights at work and that it dissipated slowly after two to three days but about two week earlier he began having pain on the right side with radiation to the front side of his leg to

the knee. He also agreed that on September 25, 2008 the doctor noted Petitioner's low back was still painful and radiating down around the right leg. He agreed that those records indicated Petitioner had experienced low back pain prior to December of 2010. (PX 2 at 37 -41) Dr. Vaught testified that it appeared Petitioner went to the chiropractor 36 times between February and September of 2007 which he would define as "intermittent" and not constant. (PX 2 at 42)

Dr. Vaught further testified on cross-examination that while Petitioner had low back pain during 2007 he was primarily diagnosed with SI joint dysfunction which is back pain but not mechanical low back pain or radicular pain. (PX 2 at 44) He also acknowledged that the doctor's notes from that time refer to low back pain ("lbp"). When asked how the doctor came up with Petitioner's diagnosis of SI joint dysfunction during that period he testified that he was not the doctor then and did not diagnosis Petitioner with it. (PX 2, p. 46)

Dr. Vaught was asked about the dates of injury provided to him. He testified that he did not have a date for the December injury. It was his understanding that the January date was around January 10th. (PX 2 at 47) He further testified that he knew Petitioner last worked on January 10, 2011. When asked if Petitioner ever gave him a specific date of accident, the doctor replied, "I do not have a specific date. He recalls two specific incidents, which are documented here, but I don't have the specific date." (PX 2, p. 48)

Dr. Vaught was asked about a date of injury "3/1/11" as stated on page one of his report. He testified that it was an error as he didn't know where that date came from. When asked if he had received copies of Petitioner's Applications for Adjustment of Claim (one of which referenced a March 1, 2011 accident) Dr. Vaught replied that he had not. (PX 2, p. 49)

Dr. Vaught reiterated that his causation opinion was based entirely upon the history provided by Petitioner at the time of the examination. He also reiterated that such history was the same one contained in the letter from Petitioner's attorney. (PX 2, p. 50)

Dr. Vaught testified that he performed the focal neurologic examination regarding Petitioner's back and legs and Ms. Alexander did a complete neurological examination. He further testified that there is a "glitch" in his office system which is why it appears the letter to Petitioner's attorney was signed by Ms. Alexander. He reiterated that he performed the examination and not Ms. Alexander. Ms. Alexander assisted him in the preparation of the report; however, he reviewed the report. (PX 2 p. 50 – 58)

On redirect examination Dr. Vaught discussed the histories Petitioner provided to his various treating physicians and chiropractors. (PX2 at 69) He further testified that nothing asked of him on cross-examination would change any of his opinions. (PX 2, 61)

On further cross-examination the following exchange occurred:

> Q. …do you have an opinion within a reasonable degree of medical certainty as to whether or not that gap of almost two years [October of 2008 to October of 2010 or January of 2011] is an indication that the problems that

> he sought treatment for in 2007/2008 is not related to the treatment he subsequently had after December, 2010?
>
> A. It was my opinion that the problems that he sought treatment for after December, 2010 was quantitatively different and consistent with a herniated disc. (PX 2 at 65)

On further cross-examination Dr. Vaught was asked about Dr. Wittenauer's note of January 13, 2011. Based upon what was contained in that note, Dr. Vaught was of the opinion Petitioner, on that date, had a herniated disc causing right sciatica; however, he could not testify to a reasonable degree of medical certainty what specific incident caused that pain. (PX 2 at 66) He also testified that he could not state what specific incident was the cause of Petitioner's complaints at the January 14th visit with Dr. Hayward. (PX 2 at 66-67)

On further redirect examination Dr. Vaught was asked if he ever spoke with Petitioner about the histories he gave to the various providers when they met on April 6, 2015. Dr. Vaught testified that Petitioner told him his main priority when he was first seeking care was to get his pain addressed because it was severe and unlike anything he had experienced previously. (PX2 at 69) Petitioner told Dr. Vaught he used his private insurance and he didn't have work comp coverage. (PX2 at 69) Petitioner told Dr. Vaught he was not setting up any sort of workers' compensation claim, he was merely focusing on his pain. (PX2 at 70)

Report and Deposition of Dr. Crane

After Dr. Vaught's deposition and on/about September 18, 2015 Dr. Benjamin Crane performed a records review for Respondent and issued a report thereafter. In a one-page, undated letter addressed to Respondent's attorney, Kelly Phelps, Dr. Crane stated he reviewed the records provided to him concerning Petitioner. Dr. Crane stated:

> [Petitioner] has been under the care of a chiropractor for quite some time but ultimately ended up under the care of Dr. Vaught when he underwent what sounds like a single level TLIF at the L4-5 level for back pain and possibly leg pain. In reviewing the medical record, I do not see any reference to a specific injury at work, with the exception of the Independent Medical Evaluation and ultimate surgery performed by Dr. Vaught. The chiropractic notes failed to state any significant work-related injury for any of his visits dating all the way back to 2007. (RX 2, dep. ex. B)

Dr. Crane was unable to causally relate Petitioner's low back condition to any specific work accident based upon the history contained in the medical record nor could he causally relate the necessity for Petitioner's surgery in June of 2011 to any specific work accident based on the histories contained in the medical records. (RX 2, dep. ex. B)

Dr. Crane was deposed on October 28, 2015. Dr. Crane testified that he is an orthopedic spine surgeon who was board certified in 2010. (RX2 at 5-6) He testified he performed a medical records review at Respondent's attorney's request. (RX2 at 6) He testified he reviewed records from one of Petitioner's chiropractors, the record from Dr. Vaught, and "some of the care by Dr. Hayward." (RX2 at 6)

Dr. Crane admitted he was at a disadvantage in this case because he did not take a history directly from Petitioner. (RX2 at 36-37) He testified that obtaining a history from a patient is almost the most important thing he does when he meets a patient. (RX2 at 8) Dr. Crane likes to know exactly how the patient hurt themselves, and what situation they were in. (RX2 at 8)

Dr. Crane testified that he could not casually relate Petitioner's symptoms and subsequent surgery in 2011 to his claimed work accident based on his review of Petitioner's records, which he testified contained no indication of a work injury that would necessitate Petitioner's back pain. (RX2 at 7)

Dr. Crane testified his report did not identify any specific records that he may or may not have reviewed, other than Dr. Vaught's report. (RX2 at 14-15) He also testified his report referenced a single, unidentified chiropractor. (RX2 at 15) He conceded that a person reading his report would know only that he read a report from Dr. Vaught and from an unidentified chiropractor. (RX2 at 15)

Dr. Crane also testified that his report stated Petitioner had been under the care of a chiropractor "for quite some time." (RX2 at 16) He explained that this referred to Petitioner's chiropractic treatment by Dr. Eaton at Du Quoin Chiropractic Center. (RX2 at 16) Dr. Crane conceded, however, that these records indicated Petitioner was seen for a few months in 2007, followed by a year-long gap. (RX2 at 17). The records also showed chiropractic care in September and October of 2008, followed by a gap of one year and five months. (RX2 at 16)

Dr. Crane also testified that following the one year and five month gap, Petitioner's records then indicated chiropractic visits in March of 2010. (RX2 at 17-18) He noted that the record from Wittenauer Clinic dated March 30, 2010 documented left sacroiliac articulation and left lower back pain, rated at 6 out of 10. (RX2 at 19)

Dr. Crane agreed there was not another record of treatment with Dr. Wittenauer following the March 30, 2010 visit, and further conceded there was no record of any treatment whatsoever for any condition following March 30, 2010, until after December of 2010. (RX2 at 19-20)

Dr. Crane testified that his Petitioner's chiropractic records from March of 2010 documented left-sided symptoms Petitioner rated at 6 out of 10, but his chiropractic records from January of 2011 documented right-sided symptoms he rated at 10 out of 10. (RX2 at 25-26)

Dr. Crane also testified that his reference to workers' compensation claims came not from Petitioner's medical records, but from Respondent's attorney's letter to Dr. Crane. (RX2 at 15-16)

Dr. Crane testified that he recognized the day before his deposition that he misidentified Petitioner's surgeon in his report. (RX2 at 7) He admitted his report stated Petitioner underwent "what sounds like a single level TLIF at the L4-5 level." (RX2 at 20) He testified he reviewed Dr. Hayward's operative report. (RX2 at 20-21) He conceded Dr. Hayward documented not a one-level lumbar surgery, but a four-level lumbar surgery. (RX2 at 22) He testified his own report was inaccurate. (RX2 at 22)

Dr. Crane testified he reviewed Dr. Vaught's record, which contained histories of two specific instances of Petitioner lifting and carrying sheetrock and materials as part of his employment. (RX2 at 23-24) Dr. Vaught's record also stated Petitioner reported he had not returned to work for Respondent since January 10, 2011 because of his symptoms. (RX2 at 24)

Dr. Crane admitted the history of Petitioner's symptoms documented in Dr. Wittenauer's January 13, 2011 note was consistent with the histories of accident documented in Dr. Vaught's report. (RX2 at 26-27)

Dr. Crane admitted Dr. Cochran's note of January 26, 2011 contained a history of severe low back pain radiating into Petitioner's right lower extremity for several weeks. (RX2 at 27). This was also consistent with the histories of accident documented by Dr. Vaught. (RX2 at 27-28).

Dr. Crane testified the January 26, 2011 note from Dr. Cochran documented a history of first noticing symptoms after lifting drywall. (RX2 at 28) Dr. Crane agreed that this reported mechanism of injury was consistent with the histories contained in Dr. Vaught's record. (RX2 at 28)

When asked whether Dr. Cochran's note from January 26, 2011 that Petitioner's symptoms began after lifting drywall was inconsistent with the statement in his report that there was no reference to an injury at work, Dr. Crane was equivocal. (RX2 at 28-29) He testified that while there was a distinct possibility he was referring to a work accident, the record did not specify a date. (RX2 at 29)

Dr. Crane conceded the mechanism of injury documented by Dr. Cochran on January 26, 2011 was documented a few weeks following Petitioner's alleged work accidents. (RX2 at 30) He further conceded that Petitioner's symptoms continued after December 2010 with no gaps in treatment until he had surgery. (RX 2 at 30) This was consistent with the histories documented by Dr. Vaught. (RX 2 at 30)

Dr. Crane admitted Petitioner always had gaps in his chiropractic care of months or even years prior to his alleged work accident, but there were no gaps following his initial visit to Dr. Wittenaeur on January 13, 2011. (RX2 at 31)

Dr. Crane admitted that if the histories of accident contained in Dr. Vaught's record were correct, then those accidents could have caused Petitioner's back and leg pain. (RX2 at 34) Dr. Crane testified that, to a reasonable degree of medical certainty, if Petitioner suffered the two

work accidents he described to Dr. Vaught in December of 2010, those accidents might or could have caused or aggravated Petitioner's low back condition. (RX2 at 34-35) The mechanism of injury as documented by Dr. Vaught could have caused or aggravated Petitioner's low back condition. (RX2 at 35)

Dr. Crane testified he was not offering any opinion as to the reasonableness and necessity of any of Petitioner's treatment, only that the treatment was not causally related to Petitioner's claimed work accidents. (RX2 at 35-36)

Dr. Crane testified he has been performing independent medical examinations or records reviews on behalf of insurance companies and defense attorneys since he came to St. Louis in 2008. (RX2 at 10-11) Approximately 5 to 10 percent of Dr. Crane's practice is dedicated to IMEs. (RX2 at 11) He testified the legal work he performs is split between plaintiffs and defendants. (RX2 at 12)

The Arbitration Hearing

Petitioner's cases proceeded to arbitration on June 13, 2017. At the time of arbitration Petitioner voluntarily dismissed the following claims: 12 WC 33621; 12 WC 33656; 13 WC 10922; and 13 WC 10928. Respondent was represented by Attorney Phelps in case number 12 WC 26843 and 13 WC 10931. Attorney Hoffman represented Respondent in case number 12 WC 26857 and 13 WC 10760.

At the beginning of the hearing Petitioner moved to amend the date of accident in 12 WC 26843 to December 3, 2010, which was granted. Petitioner also moved to amend the date of accident in 12 WC 26857 to February 23, 2007 which was granted and to amend the date of accident in case 13 WC 10931 to December 23, 2010 which was granted.

With regard to case # 12 WC 26843 (D/A – 12/3/10) the disputed issues were: accident; notice; medical bills; temporary total disability benefits; and nature and extent. (AX 1)

With regard to case # 12 WC 26857 (D/A – 2/23/07) the disputed issues were: accident; notice; causal connection; and nature and extent. (AX 3)

With regard to case # 13 WC 10931 (D/A – 12/23/10) the disputed issues were: accident; notice; causal connection; medical bills; temporary total disability benefits; and nature and extent. (AX 7)

With regard to case # 13 WC 10760 (D/A – 9/2/08) the disputed issues were: accident; notice; causal connection; and nature and extent. (AX 5)

Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he is married and his highest level of education was twelfth grade. Petitioner worked for Respondent approximately sixteen years. He last worked for Respondent on January 12, 2011.

Petitioner testified that he worked for Respondent as a delivery handler. In that position he filled customer orders, consisting of shingles, sheet rock, lumber, windows, doors, concrete, concrete blocks, and any other building materials. Petitioner would get an order off the board, pick up the materials, and deliver them to customers. Petitioner further testified that the shingles he handled and delivered came in packages weighing between 75 and 95 pounds per bundle. Additionally, the sheet rock Petitioner handled and delivered weight approximately 100 to 275 pounds per package, depending on the width of the sheet rock. Petitioner testified that sheet rock was 5/8 inches and 12 feet long and weighed approximately 275 pounds.

Prior to the instant claims, Petitioner had never filed a workers' compensation claim.

Petitioner testified that he sustained a work accident in "February of 2007." He explained that he was pulling material out of a bin to load it on the truck and he heard "something" in his back. He thought it was 2 X 8s, 2 X 10s, or 2 X 12s. When asked what part of his body was affected, Petitioner replied that he didn't know for sure but he "knew" it was the lower part of his back. He rated his pain as a "6/10." He went to Bruce Zoller as he "couldn't do it any longer" and Bruce told him to take it easy and see how he did. Petitioner testified that it kept getting worse and he told Bruce he needed to go to the chiropractor and Bruce told him to go. Petitioner also testified that he received some chiropractic treatment from Dr. Eaton and had to start paying for them. He then approached Bruce and told him that wasn't right because it should be workers' compensation since he was hurt pulling materials out of the bin for him. According to Petitioner, Bruce told him that since he paid his health insurance he wanted to keep it off workers' compensation. Petitioner testified that Bruce and Clarence Zoller own the lumber company. Bruce was his boss. According to Petitioner, Bruce Zoller told him he would speak to Dr. Eaton and that Petitioner should keep treating with him. Petitioner testified that he would have filed a workers' compensation claim if Mr. Zoller hadn't told him otherwise.

Petitioner also testified that Dr. Eaton never recommended an MRI or CT scan following the 2007 accident nor was he referred to a surgeon. Petitioner didn't miss any work after the 2007 incident. He would just take it easy when necessary and then return to his regular duties after he felt his strength returning. After some treatment with Dr. Eaton, Petitioner was able to return to full duty work with no restrictions.

Petitioner further testified that he did not undergo any treatment for his low back between October 31, 2007 and September of 2008. He then sustained another accident while lifting shingles and putting them on the laddervator to deliver to some homeowners. As he was getting down to the bottom of a pallet of shingles, he twisted and felt "something" hurt along with pain in the left side of his lower back. He then returned to see Dr. Eaton, the chiropractor. During this time, Dr. Eaton never recommended an MRI or CT scan nor was he referred to a surgeon. He rated his pain as a "5/10."

Petitioner testified that he told the secretary, Beverly Wisely, and Bruce Zoller about this accident. Mr. Zoller, according to Petitioner, told him he would speak to the doctor and once he was better the company would pay the doctor. He didn't file a workers' compensation claim on this accident for the same reason as the earlier one. Petitioner didn't miss any time from work

because he just reported to work and took it easy when needed. He eventually returned to full duty work without any restrictions.

Petitioner further testified that he didn't undergo any further treatment after the 2008 incident until March of 2010 when he returned to Dr. Eaton; however, he didn't feel any of that treatment was due to a work accident. He also recalled seeing Dr. Wittenauer on March 30, 2010 but thought it was for his shoulder and upper back. When asked if he would disagree with the records if they reflected left-sided sciatic pain, Petitioner replied "No." Petitioner continued working full duty for Respondent during this time and up through December of 2010.

Petitioner testified that on December 3, 2010 he delivered an order to Alongi's Restaurant in Du Quoin, Illinois, consisting of 11 sheets of 4 X 12 5/8 in. sheet rock and 2 x 4s for an addition to the restaurant. He reviewed a work order for this delivery dated December 3, 2010 confirming this delivery. (PX10) Petitioner testified he did not have access to this work order after he was no longer employed by Respondent, and he also did not have access to that work order at the time he filed any of his Applications for Adjustment of Claim. It was not until PX 10, and other, work slips were provided to his attorney that Petitioner had access to this work slip. Petitioner testified that once he reviewed PX 10 and other work tickets, he was able to pinpoint the date of a work-related injury he sustained, which was December 3, 2010.

Petitioner testified that the packets of sheet rock he deliverd to Alongi's weighed approximately 275 pounds per packet. He, an Alongi's employee, and another gentleman were helping Petitioner. Petitioner explained that he had one end of the packet of sheet rock and the employee had it on the other end, but the packet would bow when you picked it up to take it off the forks. When they stood to lift the sheet rock off the fork lift, it jerked, and almost took Petitioner to the ground. Petitioner testified he felt a bad snap in his low back, and felt pain in his low back and right lower extremity following this accident. He rated his pain as 10 out of 10. He also felt a burning and stinging sensation. Petitioner testified that prior to December 3, 2010, he had never experienced symptoms like the ones he experienced after this accident because this time he felt a snap and a burning and stinging sensation. Petitioner testified these symptoms were very different that the ones he had experienced nine months earlier in March of 2010.

Petitioner testified he notified his boss, Bruce Zoller, about this accident. According to Petitioner, Mr. Zoller told him to take it easy and go to the chiropractor. Petitioner testified that he continued to work despite his symptoms, albeit on modified duty. He testified he did not seek immediate treatment, but knew he had vacation coming up between Christmas Day and New Year's Day, and hoped if he took it easy until vacation that his symptoms would improve. He testified his symptoms did not improve.

Petitioner testified that until the Christmas break he continued to work but his symptoms didn't go away. They then recurred on December 23, 2010, when he made a delivery to a customer, Carl Goldman, consisting of 16 4 X 8 by 1/2 in. pieces of sheet rock. After that incident, his symptoms continued to worsen. Petitioner reviewed another work order for this delivery dated December 23, 2010 confirming this delivery (PX11).

Petitioner testified he did not have access to PX 11 after he was no longer employed by Respondent, and further did not have access to PX 11at the time he filed any of his Applications for Adjustment of Claim. It was not until PX 11, and other, work slips were provided to his attorney that Petitioner had access to this work slip.

Petitioner testified that once he was able to review PX 11and other work tickets, he was able to pinpoint the date of a work-related injury he sustained, which was December 23, 2010. (PX11).

Petitioner testified that on December 23, 2010, he was delivering sheet rock to, and picking up returns from, Mr. Goldman's house. According to Petitioner, Mr. Goldman was constructing a new home, and Petitioner was required to duck low to go out from the doorways. Petitioner was carrying three pieces of sheet rock, weighing approximately 75 pounds each, out of Goldman's house. He ducked low to exit a doorway, and felt his low back pop again in the same place as he felt after the incident at Alongi's.

Petitioner testified he had the same pain, stinging, and burning in his low back and right lower extremity as he did following the incident at Alongi's three weeks prior. He rated his pain following this incident as 10 out of 10.

Petitioner testified he notified Mr. Zoller of this accident and Mr. Zoller told him to take it easy, that vacation was coming up, and perhaps Petitioner would get better while off on vacation.

Petitioner testified it was commonly known that Mr. Zoller would not allow injured workers to receive workers' compensation benefits because he paid for their group health insurance. Petitioner testified it was that way for his 16 years of employment.

Petitioner testified his symptoms did not get better during the holiday; rather, they kept getting worse. He testified he attempted to return to work in January of 2011, and worked for around seven days, during which he just sat around as he could hardly do anything.

Petitioner testified that around January 10, 2011, he got up to go to work and could not even bend over to pull his socks up or his shoes on. He called Mr. Zoller and told him about his condition. According to Petitioner, Mr. Zoller told him to just stay home and see if his condition improved. Petitioner testified that his condition did not improve and he was unable to return to work again.

Petitioner was required to seek treatment for his condition. His pain and stinging in the right side of his back and his right leg was so bad he could hardly stand it. He rated his pain as 10 out of 10 at that time.

Petitioner testified that he first sought treatment at Wittenauer Chiropractic in January of 2011. He was experiencing pain in the right side of his back. He also noticed a stinging sensation and right leg pain. When asked if he happened to tell anyone at Wittenauer Chiropractic about his injury he testified that he thought he did but he couldn't swear to it.

Petitioner testified he also saw Dr. Cochran, another chiropractor, in January of 2011. He started paying him and told the doctor it wasn't right that he was paying for the treatment when it happened at work but his employer wouldn't let him proceed under workers' compensation since it provided him with his health insurance. According to Petitioner, Dr. Cochran got hold of Bruce Zoller and he gave Petitioner his money back. From then on the doctor couldn't do anything for him and he referred him to Dr. Hayward.

Petitioner testified when he first came under the care of Dr. Hayward, he saw Dr. Hayward's physician's assistant. He remembered the PA's name was Chris. He testified he told Chris he hurt his back working for Respondent and that it should be processed as a workers' compensation claim, but because of Mr. Zoller's statements and policy concerning injured workers not being entitled to workers' compensation benefits because Respondent provided group health insurance, Petitioner told Chris he was required to process the treatment under his group health insurance.

Petitioner testified that PA Chris was the last medical provider to whom he gave a history of his two work accidents in December of 2010 because of Mr. Zoller's statements. He saw at least three more PAs prior to seeing Dr. Hayward, but did not mention to them or to Dr. Hayward his December 2010 work accidents because of Mr. Zoller's requirement that Petitioner use his group health insurance.

Petitioner was asked if he told Dr. Hayward or any of the PAs about the work accidents at Alongi's and Mr. Goldman's and he replied "no" because he was in so much pain at that time he could hardly stand.

Petitioner testified he underwent lumbar injections at Southern Illinois Pain Management. He testified he did not give anyone at Southern Illinois Pain Management a history of his accident at Alongi's or at Goldman's house. Petitioner did not recall giving a history of his pain beginning on January 12, 2011. He testified January 10, 2011 was the date he could not get his socks on, and testified that pain was continuing pain from the accidents at Alongi's and at Carl Goldman's house. His pain did not begin in January of 2011; rather, his pain got so severe at that time that he could not put his socks or shoes on.

Petitioner testified he eventually underwent lumbar surgery on June 23, 2011 performed by Dr. Hayward. He testified he did fine following surgery. He testified he is unable to lift over 50 pounds, and can hardly do any stooping because of ongoing pain. He still has pain in the same locations in his low back and right leg and his functions are limited greatly due to this pain. Petitioner is unable to perform his job duties for Respondent.

Petitioner testified his group health insurance at the time was an 80/20 plan, requiring him to pay 20 percent of his charges out of pocket. He testified he paid more than $5,000.00 out-of-pocket for medical treatment in 2011.

Petitioner testified he last saw Dr. Hayward in 2012, and had to pay for that visit himself, as he no longer had group health coverage. This included paying for an x-ray of his lumbar

spine. His group health was cancelled as of January 1, 2012. Dr. Hayward wanted to see Petitioner again, and wanted Petitioner to obtain a CT scan or MRI. Petitioner explained he could not afford either of those scans, and Dr. Hayward settled for an x-ray, which was all Petitioner could afford. He has not returned to Dr. Hayward.

Petitioner testified that in 2015 he met with Dr. Kevin Vaught in Cape Girardeau, Missouri. He testified he actually met with Dr. Vaught, not just Dr. Vaught's PA, and that Dr. Vaught actually performed a physical examination on him. Petitioner testified Dr. Vaught placed permanent restrictions on him, and that Respondent never offered to accommodate those restrictions or bring Petitioner back to work. Respondent never offered Petitioner vocational rehabilitation services or any assistance any sort of job search.

Petitioner testified he has never heard of Dr. Benjamin Crane, and that he had never been examined by him.

On cross-examination, Petitioner testified his pain was a "10/10" after he got hurt in early December of 2010. He agreed that he didn't get any treatment but he continued to show up for work. When asked if he actually worked, he replied he did not as he mostly sat around because he could do very little. He denied making any deliveries after December 3rd. He then testified that he started making some deliveries because he guessed the inflammation went down but those deliveries didn't begin until shortly before December 21, 2010. Petitioner then clarified that he didn't think he did for "maybe four to six days." Petitioner was then asked about a delivery of wood boxes to Taylor Brothers on December 21, 2010. He testified he drove the delivery truck to Taylor Brothers, but they unloaded the materials themselves because he was unable to move them.

Petitioner was also asked about a delivery on December 20, 2010 to Dave Kent. He testified Mr. Zoller had the yard boy load the materials on the truck. Petitioner drove the truck to Dave Kent's, and they unloaded the materials.

Petitioner was asked about a delivery on December 16, 2010 to Jackie Davidson. He testified it was the same as the previous question, that Petitioner was able to drive the truck, but was unable to either load or unload the truck.

Petitioner testified he continued to make deliveries, without loading and unloading the truck, until January 10, 2011 when he was unable to return to work due to pain. Prior to January 10, 2011, he would show up every day and would either sit around, and/or sometimes drive the delivery truck, but did not load or unload the truck.

Petitioner reviewed several work orders from December 1, 2010 to January 11, 2011. (RX7). He testified that some of these deliveries were not made by him. The deliveries he made during that period contain his initials at the bottom.

Petitioner confirmed that on December 1, 2010, prior to the Alongi's work accident, he made deliveries to Searby Funeral Home, Heartland Mechanical, and Du Quoin High School.

He also confirmed that on December 2, 2010, also prior to the Alongi's work accident, he made deliveries to Terry Marks, Carl Goldman, and to Brad Galli.

Petitioner testified that deliveries following December 3, 2010 were loaded by Respondent's other employees and unloaded by the customers themselves, as he was unable to load or unload the truck due to his work injury of December 3, 2010.

Petitioner testified that his last day of work for Respondent was January 10, 2011. He was then shown a delivery ticket for January 11th and agreed it had his initials on it but he had no explanation. He thought the 10th was a Tuesday morning and the last day he went in to work. He agreed that the work slips show he continued to work and that he drove the truck and forklift making deliveries. He also agreed that he sought no medical treatment in December of 2010.

Petitioner confirmed on cross-examination that the first time he sought medical treatment following his injuries at Alongi's and at Goldman's house was on January 13, 2011 with chiropractor Dr. James Wittenauer. Dr. Wittenauer's note documented that Petitioner's symptoms were worse when he did nothing because they were always there. Petitioner testified this was true after he was injured. He testified he may have failed to mention his December of 2010 work accidents at that visit, but those accidents were the reason he was there. Petitioner testified the notation in Dr. Wittenauer's records of symptoms beginning December 30, 2010 was inaccurate, and that someone must have written it down wrong.

Petitioner agreed that he underwent chiropractic treatment for left-sided low back pain beginning in February of 2007. Despite an entry in Dr. Eaton's September of 2008 records to the contrary, Petitioner did not believe he had prior right-sided low back pain in September of 2008. He was shown Dr. Eaton's record from September 23, 2008, and conceded the record indicated complaints of right low back and right leg pain, but he testified he recalled his pain being on the left side at that time.

Petitioner also agreed that he underwent chiropractic treatment from February of 2007 until September of 2007. He believed during that time he underwent 28 chiropractic treatments. He also agreed that in September and October of 2008 he underwent seven (7) chiropractic treatments.

On further cross-examination, and contrary to his testimony on direct examination, Petitioner indicated that his treatment in March of 2010 was due to a work accident. He did agree that his complaints in March of 2010 were on his right side. He added, however, that his right-sided complaints began in December of 2010. Petitioner then testified that he didn't remember seeing a chiropractor in March of 2010 as he did not see one until 2011.

Petitioner was shown Dr. Eaton's visits from March of 2010. Petitioner testified that he did not see the doctor at that time. He further testified that there is another "Steve Fred" in DuQuoin and "that was not me." He did agree that he saw Dr. Eaton in October of 2008.

Petitioner testified that Dr. Cochran referred him to Dr. Hayward. When asked about Dr. Hayward's note indicating he was referred by Dr. Furry, Petitioner testified Dr. Furry was his family doctor, but that Dr. Cochran had actually referred him.

Petitioner reiterated that his symptoms began after the two incidents at Alongi's and Goldman's house despite the notation in Dr. Hayward's records that his symptoms began in January of 2011. He testified he did not review Dr. Hayward's records prior to arbitration.

Petitioner reiterated on cross-examination that he told Dr. Hayward's PA Christopher Hodges about his two December of 2010 work accidents despite them not being documented in the initial treatment record of February 23, 2011. He further testified that he may have told the doctor it began in January of 2011 but it really started in December of 2010.

Petitioner testified he was seen at Southern Illinois Pain Management on March 2, 2011. He confirmed the note from this visit stated his symptoms began after awakening from sleep on January 12, 2011 with no new injury, but he testified his symptoms began in December despite what was documented in this record. Petitioner testified the Southern Illinois Pain Management record from March 2, 2011 does not accurately describe what had happened to him.

Petitioner denied that his low back condition simply gradually got worse over time while working for Respondent. He testified that "when something hits you like that and takes you almost to your knees, you know that's when it happened." Petitioner testified he was one of the strongest men who ever worked for Respondent, but following the two incidents in December of 2010, he could not perform his duties anymore.

Petitioner agreed there was no incident or accident that occurred in January of 2011. Petitioner testified that on January 10, 2011 his pain got so bad that he could no longer stand it and could no longer even drive. He again related that pain to the two incidents in December of 2010.

Petitioner testified he saw Dr. Hayward for the last time on June 22, 2012 after he had his lumbar x-ray made. Dr. Hayward's note indicated he would most likely release Petitioner from care after a one-year follow up. Petitioner did not follow up in 2013 with Dr. Hayward because he could not afford it, as his group health insurance had been cancelled.

Petitioner testified he saw Dr. Vaught on the advice of his attorney. Dr. Vaught did not render any treatment, but examined him, and advised him to apply ice every 20 minutes. He saw Dr. Vaught once.

Petitioner testified he has not sought work since retiring in 2016, when he turned 66 and began receiving Social Security benefits. Prior to that, he had received social security disability benefits, but was not a Medicare recipient.

Petitioner testified it was not accurate to say his low back pain developed in 2007 and continued until he quit working in January of 2011. He testified his prior low back pain resolved in 2008.

Petitioner testified he first saw chiropractor Dr. Eaton in 2002 for what he believed to be a shoulder issue. He treated with Dr. Eaton beginning in February of 2007 for a low back condition, during which time he continued to show up to work. He lost no time.

Petitioner testified that at the end of his treatment with Dr. Eaton in 2007, he was released to work full duty with no restrictions. He also testified that his back pain was "completely gone" after 2008. He then did not seek any further treatment until January of 2011.

On further cross-examination Petitioner agreed that he saw Dr. Eaton in for several months in 2007 for left-sided back pain. During that time he continued to work or, as he described it "showed up.' He did not lose any time from work. He was released with no restrictions in 2007.

Petitioner further testified that after another incident he returned to Dr. Eaton in September of 2008. Petitioner again treated with Dr. Eaton approximately seven (7) times from September to October, 2008 for left-sided back pain. After those seven visits, Petitioner quit going to Dr. Eaton because he felt good enough to work full duty without restrictions. He returned to his full duty work at that time. He lost no time following the 2008 work accident.

Petitioner further testified that he had no back problems from October of 2008 until his two work accidents in December of 2010 and his symptoms following those work accidents were right-sided.

On redirect examination Petitioner confirmed that he reviewed the work tickets from December 1, 2010 to January 11, 2011. (RX7) He testified that his initials on a work ticket did not mean that he physically loaded and unloaded materials. He was responsible for making sure the materials on the ticket were delivered. After he was injured on December 3, 2010, he testified that even Mr. Zoller told customers they would be required to unload the materials themselves, and Mr. Zoller had other employees load the materials for Petitioner; however, he could still drive at that point.

Petitioner testified that, assuming he underwent chiropractic treatment in March of 2010, approximately nine months prior to December of 2010, he received no other treatment after March of 2010. He saw no chiropractor, physician, surgeon, or any other medical professional from March of 2010 until after his work accidents at Alongi's and Carl Goldman's house.

Petitioner testified he knew for certain he was injured at Alongi's on December 3, 2010, and at Carl Goldman's house on December 23, 2010. He denied simply picking two dates.

Petitioner was shown an Application for Adjustment of Claim with a date of accident of "December 2010." (RX1; see also AX2). Petitioner testified he could not remember the exact date of this injury until he reviewed the work order tickets. He knew it had been in the month of December.

Petitioner admitted filing other Applications for Adjustment of Claim claiming dates of accident of December 1, 2010, December 7, 2010, January 4, 2011, January 12, 2011, and March 2, 2011. Petitioner testified these were filed before he reviewed the work order tickets.

Petitioner testified that the Application for Adjustment of Claim for Case No. 12-WC-26843, on which the date of accident was amended to December 3, 2010, described an incident lifting sheet rock and roofing shingles to customer Alongi's Restaurant in the regular course of employment. Petitioner testified he had always been able to identify Alongi's Restaurant as the location where he was injured. The work ticket from December 3, 2010 described the same delivery to Alongi's as was described in his Application for Adjustment of Claim. (PX 10)

Petitioner was also shown an Application for Adjustment of Claim with a date of accident December 7, 2010. Petitioner testified that the location of the accident contained in this Application for Adjustment of Claim was Carl Goldman's house. (RX1)

Petitioner testified it was "fair to say" he knew he had been injured at Alongi's and at Goldman's house even prior to reviewing the work tickets. The work order tickets for Alongi's on December 3, 2010, and for Carl Goldman on December 23, 2010, confirmed the actual dates for Petitioner. (PX10; PX11)

Petitioner was asked why he filed so many Applications for Adjustment of Claim if he knew he had been injured at Alongi's and at Goldman's house. Petitioner testified he did not know, and that perhaps it was because his attorney told him to. Regardless, Petitioner testified that once he got the work order tickets, he knew exactly when he had been injured. He always knew where, but the work tickets confirmed when.

The Arbitrator concludes:

Petitioner's Credibility.

At the outset the Arbitrator notes that, initially, Bruce Zoller's absence was troubling given Petitioner's testimony as to comments by him as well as his alleged business practices regarding the handling of work injuries. However, as she reviewed the record and the testimony of Petitioner this became less of a concern as she determined that Petitioner, himself, was not a credible witness and his testimony about Mr. Zoller may have been largely self-serving given the disputed issues of accident and notice in all four of his claims. Furthermore, the take-away from Petitioner's testimony was the suggestion that he didn't want to mention a work accident to any doctors so that his group health would cover the costs per Mr. Zoller's "wishes." However, Petitioner had been working for Respondent for seventeen years. He had mentioned work accident in prior visits (2002 and 2008) and he had told Dr. Sowerby about gradually developing work-related problems.

There were other inconsistencies in, not only Petitioner's testimony on direct examination and cross-examination but between his testimony and what is found in the medical records.

Petitioner testified that he had no right-sided back/leg complaints in September of 2008. Dr. Eaton's records show otherwise. Petitioner acknowledged having some low back treatment in March of 2010 and some right-sided complaints during that time but further claimed they were unrelated to any work accident. He then testified to the contrary on cross-examination as he denied any treatment in March of 2010 whatsoever and further claimed there was another person with the same name as his living in DuQuoin who must have had that treatment; however, no steps were taken to clarify this by affidavit or deposition of the doctor. Furthermore, it seems strange that, if Petitioner didn't treat in March of 2010 as shown by the records, why was Dr. Vaught asked to assume that he did? There was also Dr. Eaton's note of 2011 in which he stated he had last seen Petitioner in March of 2010. Finally, there was Dr. Wittenauer's reference in January of 2011 to having last seen Petitioner in March of 2010. Thus, two of Petitioner's treating doctors acknowledged treating Petitioner in March of 2010 contrary to Petitioner's testimony.

Petitioner presented to Wittenauer Chiropractic on January 13, 2011 with a "new problem" that the doctor attributed to an onset date of December 30, 2010. The doctor also noted that his diagnosis from December 30,2010 needed to be amended. Petitioner, on cross-examination, was asked about the history and testified it was wrong and that someone must have written it down wrong. Petitioner knew accident was in dispute with regard to his claims and, yet, he undertook no effort prior to arbitration to correct a possible scrivener's error or otherwise address what he felt was a mistake. His explanation for the history wasn't persuasive.

A review of Dr. Sowerby's March of 2011 report shows that Petitioner told the doctor he had noticed gradually increasing back pain with the work he had been doing over the years as a delivery person. (RX 6) However, at the hearing Petitioner denied any gradual pain stemming from work duties and he voluntarily dismissed his claims based upon repetitive trauma thereby seeming to contradict any history provided to Dr. Sowerby. Again, another inconsistency.

Another major inconsistency stems from Petitioner's testimony regarding his level of activity at work after the alleged December 3, 2010 accident. Petitioner testified that after his alleged December 3, 2010 accident he was unable to work full duty for Respondent (ie. lift and carry) as his symptoms weren't going away so he worked "modified duty." He testified that he then had another accident on December 23, 2010 while carrying sheet rock out of Carl Goldman's home. On cross-examination Petitioner was asked if he actually worked after December 3rd and he replied that he mostly sat around "because he could do very little." Petitioner also denied making any deliveries after December 3rd but then acknowledged making some deliveries because "he guessed his inflammation had lessened." Petitioner was also asked about a number of delivery tickets bearing his initials. He testified that he only drove the delivery truck and that others loaded and unloaded because he was unable to do so. Petitioner further testified that he only sat around at work or drove the delivery truck and others loaded and unloaded because he was unable to do so. If Petitioner is to be believed regarding his inability to physically do anything for Respondent after December 3, 2010 then his testimony about sustaining another accident on December 23, 2010 is untrue as, by his own testimony, he couldn't have been carrying anything at Carl Goldman's home. Alternatively, if his testimony about his level of activity was not true then he continued to work full duty making deliveries. Either way, Petitioner's believability has been undermined.

Yet another credibility issue surfaced regarding Petitioner's testimony regarding his referral to Dr. Hayward. Petitioner testified that Dr. Cochran referred him to Dr. Hayward. That is not corroborated by Dr. Cochran's records. Furthermore, Dr. Hayward's records indicate "Dr. Furry" (Petitioner's family doctor – see p. 20 of PX 3) was the referring physician (and Dr. Furry received copies of all office notes from Dr. Hayward). Petitioner provided absolutely no testimony as to why Dr. Furry referred him to Dr. Hayward (since he claimed Dr. Cochran did so). Additionally, Dr. Furry's records aren't a part of the record which is troubling since it is clear from Dr. Hayward's records that the referral to a spine surgeon came from him.

Petitioner went into the arbitration hearing knowing that "accident" was an issue in each of his four cases that were going forward. With regard to the alleged accident dates in December of 2010, it wasn't just the date of accident being disputed but also the mechanisms of injury and lack of any real corroboration for either alleged date of accident in Petitioner's treating medical records. Petitioner testified that on December 3, 2010 he was delivering sheet rock to Alongi's restaurant. He testified that he was injured while lifting street rock and that two other people were working with him when it happened (one of which was an employee of Alongi's). Petitioner could have subpoenaed these people or obtained affidavits from them to corroborate his testimony. He didn't and he provided no explanation as to why he couldn't or didn't.

Similarly, Petitioner testified that he wasn't sure if he told Wittenauer Chiropractic about his December 3, 2010 accident. He also testified that he told Dr. Cochran he injured himself at work and that he told Dr. Hayward's PA-C Chris Hodges about hurting his back at work. None of the records of these treaters corroborates Petitioner's testimony. Again, Petitioner could have deposed them to obtain corroboration; however, he didn't.

Further credibility issues come to light upon reviewing Dr. Vaught's consultation exam. Dr. Vaught's report references that Petitioner told him he was unable to return to work for Respondent due to work restrictions recommended by Dr. Hayward. This is untrue as Dr. Hayward's office notes and records fail to mention any permanent restrictions or recommendations. It also appears that Petitioner never advised Dr. Vaught that he never returned to Dr. Hayward for a final release. Petitioner testified that Dr. Vaught recommended he use ice every twenty minutes. There is no corroboration for that within Dr. Vaught's report or deposition. Petitioner's misrepresentations undermine his credibility.

Lastly, the Arbitrator found Petitioner's testimony about his current abilities difficult to believe and contrary to the objective reports and records in evidence. Petitioner's voiced complaints and limitations at trial essentially mirrored those of the permanent restrictions imposed by Petitioner's examining physician, Dr. Vaught. In comparison is the fact Dr. Hayward, when last seeing Petitioner after his surgery, noted Petitioner was doing "extremely well" with tolerable pain complaints at most. He required no medication. Petitioner was to follow up with Dr. Hayward but didn't. There was a gap of three years between Petitioner's last visit with Dr. Hayward and his examination with Dr. Vaught. When examined by Dr. Vaught, Petitioner's physical examination was recorded as normal with only subjective complaints being noted. Dr. Vaught provided no reason as to why the permanent restrictions were necessary. He was, based upon Petitioner's history to him, erroneously under the impression Dr. Hayward had

recommended permanent restrictions. There was no corroboration by any credible objective evidence for Petitioner's testimony regarding any current limitations and difficulties.

Issue C - Did an accident occur on September 2, 2008 that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner failed to prove that he sustained an accident on September 2, 2008 that arose out of and in the course of his employment with Respondent.

It is axiomatic that an injury is accidental under the Illinois Workers' Compensation Act when the injury can be traced to a definite time, place, and cause and occurs in the course of one's employment. Petitioner is claiming a specific accident in this case, as opposed to repetitive trauma. Therefore, Petitioner bears the burden of proving he sustained an accident on a specific date, time, and location. Petitioner herein failed to meet that burden of proof.

Petitioner testified to sustaining an accident in "September of 2008." However, he never testified as to an exact date or time in September. While he testified that he notified Respondent's secretary, and Bruce Zoller, his boss and one of the owners, he did not testify as to when he spoke with either of these people. Petitioner's medical records show no treatment until September 23, 2008 at which point Petitioner returned to see Dr. Eaton, his chiropractor, and gave a history suggestive of more than one possible accident as Petitioner described pain beginning approximately three weeks earlier after moving 2 x 8s at work but which dissipated within two to three days with icing and then there was a second episode two weeks earlier when the pain returned. No specific date of accident(s) was provided. More significantly, the mechanism noted by Dr. Eaton (pain in Petitioner's left back after moving 2 x 8s at work) was completely different than what Petitioner testified to at trial (lifting shingles and putting them on a laddervator).

In summary, Petitioner's testimony as to when the accident occurred lacked sufficient detail and, furthermore, his testimony as to an alleged accident was not corroborated by any medical records. Petitioner failed to prove he sustained an accident on September 2, 2008 which arose out of and in the course of his employment. Petitioner's claim for compensation is denied and no benefits are awarded.

Issue "E" - Was timely notice of the accident given to Respondent?

Petitioner failed to prove timely notice of an accident was given. Again, Petitioner failed to testify to a specific date in September of 2008 when he injured his low back. He also failed to testify as to when he notified Mr. Zoller about the accident. Notice of an accident must be given with 45 days thereof. In this instance the Arbitrator is unable to conclude that that was done.

Petitioner claim for compensation is denied.

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

Even assuming, arguendo, that Petitioner sustained an accident on September 2, 2008 Petitioner failed to prove that his current condition of ill-being is causally related to that injury.

After his alleged accident, Petitioner did not seek any medical treatment until September 23, 2008 when he returned to see Dr. Eaton, his chiropractor with whom he had treated previously (albeit not for about one year). Dr. Eaton's office note described low back pain beginning approximately three weeks earlier on the left after moving 2 x 8s at work. He stated that the pain dissipated two or three days thereafter with use of ice but had returned approximately two weeks earlier to the visit, and now involved right-sided dull pain radiating to the front side of his leg to his knee. (RX 3)

Thereafter Petitioner continued his chiropractic treatment with Dr. Eaton with an additional two visits in September of 2008 and four (4) visits in October of 2008. (PX 4 at 4-5; RX 3) As of September 29, 2008 Petitioner felt 90 percent better with an occasional sharp pain when "twisting wrong." During the October visits, Petitioner reported only dull aching or intermittent sharp pain following walking and lifting. Petitioner underwent no further medical treatment for his low back until March of 2010, approximately 1 ½ years later. While Petitioner's testimony regarding whether or not he underwent medical care for his back in March of 2010 was contradictory as he acknowledged it on direct[6] but later denied undergoing any treatment, the Arbitrator believes the evidence in the record suggests there was some treatment in March of 2010 since Petitioner saw not just one doctor but two doctors at that time (Dr. Eaton and Dr. Wittenauer) and then returned to see Dr. Wittenauer in January of 2010 at which point the doctor noted he had last seen Petitioner in March of 2010. None of these medical records mention a September 2, 2008 accident date. Dr. Wittenauer's records note a February 28, 2010 accident. The medical histories contained in these records don't suggest or state that Petitioner was having any difficulties he associated with an accident on September 2, 2008.

Most significantly, no doctor opined that Petitioner's current condition of ill-being in his low back was caused, in whole or part, by the alleged accident of September 2, 2008. Since September 2, 2008 Petitioner has alleged additional accidents to his low back which are the subject of other claims. Finally, the Arbitrator notes Petitioner's testimony wherein he clearly indicated that his prior back pain in 2007 and 2008 resolved and was "completely gone."

Petitioner failed to prove that his current condition of ill-being in his low back is causally related to his alleged accident of September 2, 2008. Petitioner claim for compensation is denied.

Issue "L"—What is the nature and extent of the injury?

Given the Arbitrator's determinations regarding accident and causation as set forth herein, this issue is moot.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

[6] But even then Petitioner denied any of the treatment in March of 2010 was due to a work accident.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAUL FRED,

Petitioner,

vs.

NO: 13 WC 10931

18IWCC0360

DUQUOIN HOME LUMBER,

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 (TTD), and permanent partial disability (PPD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner, Paul Fred sustained a work-related injury on December 23, 2010. The Commission finds that Petitioner reached maximum medical improvement as of June 22, 2012. The Commission finds that Petitioner is entitled to all reasonable and necessary medical expenses related to the December 23, 2010 accident. The Commission further finds that Petitioner is entitled to TTD benefits from January 13, 2011 through June 22, 2012. The Commission awards Petitioner 25% man-as-a-whole.

The Commission affirms and adopts the Arbitrator's denial of claims 12 WC 26843, 12 WC 26857, and 13 WC 10760 for which separate decisions have been issued.

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.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

18IWCC0360

The Commission makes the following findings:

At the outset of the hearing, petitioner's attorney voluntarily dismissed 4 of the then 8 pending cases and proceeded to arbitration on the following 4 cases:

a) Case 12 WC 26857 was filed August 6, 2012. Petitioner alleged injury to his back while loading and unloading sheet rock and roofing shingles on February 23, 2007;

b) Case 13 WC 10760 was filed April 2, 2013. Petitioner alleged injury to his back while lifting 2x8 pieces of lumber on September 2, 2008;

c) Case 12 WC 26843 was filed August 6, 2012. Petitioner alleged injury to his back while lifting sheet rock and roofing shingles at Alongi's restaurant on December 3, 2010; and,

d) Case 13 WC 10931 was filed April 3, 2013. Petitioner alleged injury to his back while lifting at work on December 23, 2010.

The arbitrator denied the first three claims: 12 WC 26857, 13 WC 10760 and 12 WC 26843. By separate Orders we concur with the arbitrator's disposition of those three matters.

The below is a recitation of allegations made by the Petitioner and a recapitulation of certain of the evidence taken below.

1. Petitioner worked as a Delivery Handler for the Respondent, Duquoin Home Lumber for 16 years. He would deliver shingles, sheet rock, lumber, windows, doors, etc. The shingles weighed upwards of 95 pounds per bundle and the sheet rock weighed upwards of 275 pounds. T.38.

2. Petitioner alleged an injury on February 23, 2007. He was pulling 2x8s or 2x10a out of the bin to load onto the truck when heard something in his lower back. T.40. His pain was 6 out of 10. He reported the incident to the owner and boss, Bruce Zoller. Mr. Zoller told him to take it easy and go to the chiropractor, Robbie Eaton. He told Mr. Zoller that this was a workers' compensation issue. Mr. Zoller told Petitioner that he would pay for his bills if he kept it off workers' compensation. T.39. Petitioner did not lose any time from work due to his injury and only received some chiropractic care. T.43. He returned to work without restrictions. He did not receive any treatment for his low back between October 31, 2007 and 2008. T.44.

3. Petitioner alleged a second injury on September 2, 2008. He was lifting shingles and putting them on the "laddervator." He twisted and felt something hurt as he lifted the shingles. He had pain in his lower back. T.45. He informed Zoller who told him that he

would pay the medical bills. He did not miss any time from work and took it easy while working. His pain was a 5 out of 10. He only underwent chiropractic care and then did not seek any medical treatment until March 2010 when he saw a chiropractor for shoulder and upper back issues.

4. Petitioner was seen by Dr. James Wittenauer of Wittenauer Chiropractic on March 30, 2010. He reported that his condition was aggravated by bending and lifting too much. His left sacro iliac articulation was 6 out of 10, his left lower back was 6, and neck was 6 out of 10. PX.5.

5. Per the Respondent's ticket order form, Petitioner and a co-worker made a delivery to Alongi's on December 3, 2010. PX.10. He delivered sheet rock, 2x4s, and "10-foot construction," which he delivered on a forklift. Petitioner stated that the sheetrock weighed 275 pounds. T.54. He had one end of the sheetrock and, when they lifted the sheetrock off the fork lift, it jerked him and almost took him to the ground. He heard a snap in the right side of his back. His pain was 10 out of 10. T.55. He felt a snap, along with a burning and tingling sensation. He stated that this was a different sensation then any he had before the accident. T.56. He notified Zoller of the incident and was told to take it easy. He was going to be on vacation from Christmas through New Year's and hoped his condition would get better over vacation. T.57. He continued to work despite his pain.

6. Petitioner was shown the work order form for December 23, 2010 indicating he made a delivery to Carl Goldman. PX.10. He delivered 16 4x8s, and sheet rock. T.58. On this date, Petitioner felt a pop in his back when he ducked under the doorway while carrying a 75-pound piece of sheetrock. T.59. It was a needle like sensation. His pain was a 10 out of 10. T.60. He again notified Zoller and was told to take it easy and that he would get better while on vacation. T.61. His pain kept getting worse. *Id.*

7. Respondent offered the delivery tickets for Petitioner showing he made numerous deliveries between December 2010 and January 2011. RX.7. Petitioner stated that he returned to work in January 2011 and basically sat around for 7 days. T.61. Then, on January 10, 2011, he could not bend over to put on his socks. He contacted Zoller and was told to stay home to see if his condition would get better. Petitioner stated that he never got better and he never returned to work. T.62.

8. On cross-examination, Petitioner stated that he did not recall the exact day he got hurt until he received the work order slips at the arbitration hearing. T.73. He stated that he stopped working on January 10, 2011 despite the work order slip showing he made a delivery on January 11, 2011. T.90.

9. Petitioner testified that he went to Wittenauer Chiropractic in January 2011. He had symptoms in his right back and pain in his right leg. He thought he may have told someone how he got hurt. He then saw Doug Cochran, a chiropractor, and told him that it was not

fair that he was paying out-of-pocket for his medical. Doug Cochran then contacted Bruce Zoller. Doug then returned the money to Petitioner and told him there was nothing he could do for him. Petitioner was referred to Dr. Hayward of St. Francis at Cape Girardeau. T.64.

10. Petitioner followed-up with Dr. Wittenauer on January 13, 2011. He reported that "nothing in particular aggravates his problem and it is worse when he does nothing in particular as it is always there." It was noted that the diagnosis from Thursday, December 30, 2010 was amended today. PX.5. Petitioner testified that they wrote down the wrong date. T.92.

11. Petitioner presented to Dr. Wittenauer on January 14, 2011. His right sacro-iliac articulation and right sciatica was 9 out of 10. His problems become aggravated when he: "does nothing in particular because it is always there." Petitioner reported that nothing made his problem better. PX.5.

12. Petitioner underwent a consultation at Tri-County Chiropractic on January 26, 2011. The handwritten record revealed that Petitioner had been experiencing severe low back pain into the right lower extremity for several weeks. He had not worked for the past two weeks due to pain. He first noticed his pain while lifting drywall. It was noted that this occurred on the job. He did not plan on turning it into a workers' compensation issue. PX.3.

13. Petitioner testified that he saw physician assistant, Chris. He told him about the work injury and that it was workers' compensation related, but that he had to go through group health. He saw the physician assistant for 3 to 4 weeks before seeing Dr. Hayward. T.66. He never told them about the incidents at Alongi's or Carl Goodman's location. *Id.*

14. Petitioner underwent an MRI of the lumbar spine on February 8, 2011. The MRI revealed multilevel disc disease with areas of spinal stenosis and foraminal stenosis. There was an asymmetric bulge at L5-SI that extended into the inferior left foramina slightly narrowing the left foramina and possibly compressing the left L5 nerve root at the L5-SI foramina. There was a moderate to prominent left facet arthropathy with ligamentum flavum and capsular distention about the left facet indenting and compressing the left posterolateral aspect of the thecal sac. PX.3.

15. Petitioner was seen by Dr. Franklin Hayward of Heartland Spine on February 23, 2011 for lower back pain, right hip and leg pain that started in January of 2011. Dr. Hayward's record indicated that a conservative approach has not helped. He noted that the MRI revealed a disc protrusion asymmetric toward the left, multilevel disc bulging and degeneration. At L5-SI, the protrusion seemed to be touching the exiting nerve root. The assessment was right L5-SI radiculopathy. Injections were recommended. PX.9.

16. Petitioner was seen by DO Julie Sowerby of Southern Illinois Pain Management Clinic on March 2, 2011 for back and leg pain. It was noted Petitioner has a physical job and has to lift and move heavy packets of shingles. He reported that his back pain began when he

woke from his sleep on January 12, 2011. He did not have a new injury or trauma at that time. He noted difficulty performing his job due to his low back and leg pain. He noted that prior to January 12, 2011, he did not have the leg symptoms. He did not get any lasting relief from two chiropractors. His pain was a 6 out of 10. Examination revealed decreased range of motion and flexion without pain. She noted that the February 8, 2011 MRI revealed multilevel degenerative disc changes toward the right at L2-L3 and L3-L4 and toward the left at L4-L5 and L5-SI. He had spinal canal stenosis from L2-L3 and L4-L5. There was degenerative facet arthropathy at multiple levels as well. PX.8.

17. Petitioner testified that the March 2, 2011 record from SI pain management indicated that he mentioned low back pain that began on January 12, 2011. He did not have a new injury or trauma at that time. T.67. He stated that the date should have been January 10, 2011 as that was when he tried to put on his socks, which was continuing pain from his work injury at Alongi's and Carl Goldman's.

18. Petitioner underwent a lumbar steroid injection on March 7, 2011 and March 28, 2011. PX.8.

19. Petitioner was seen by Leslee Duncan, PA-C at Southern Illinois Pain Management on April 13, 2011. He reported chronic back and right leg pain. He reported that the injections did not help and he was still very uncomfortable and was unable to drive. The assessment was facet arthropathy, lumbar, without myelopathy, low back pain, chronic, lumbar degenerative disc disease and lumbar spinal stenosis. PX.8.

20. Petitioner underwent a CT scan of the lumbar spine on May 18, 2011. The impression was an L2-L3 disc herniation with disc extrusion centrally and posterior laterally to the right. There was moderate to severe narrowing right greater than left neural foramen. There was a disc herniation at L3-L4 extending posteriorly and to the right with narrowing impinge on the right neural foramen right L4 nerve root. At L4-L5, there was an osteophyte disc complex narrowing the spinal canal with mild to moderate narrowing of the neural foramen with severe degenerative changes of the facet joints. PX.7.

21. Dr. Hayward performed a transforaminal lumbar interbody fusion at L4-L5 and L5-SI, a right sided approach with laminectomy, discectomy at L3-L4 right, and laminectomy L2-L3 right on June 23, 2011. PX.9.

22. On August 8, 2011, Dr. Eaton of Duquoin Health Center authored a letter indicating petitioner had received treatment 39 times through September 7, 2007. Bruce Zoller pain $660.00 for the treatments. He did not charge his normal fees due to the number of treatments and that he was disappointed with the time frame for recovery. Petitioner then treated 7 times from September 23, 2009 through October 31, 2008. Mr. Zoller paid $180.00. PX.4.

23. Petitioner followed-up with Dr. Hayward on September 2, 2011. He was doing great and was very pleased with the outcome of the surgery. His leg pain had completely resolved. He was not taking any pain medication. The x-ray revealed good placement of the hardware. He refused therapy as he did not need it. He was to follow-up in 12 weeks. PX.9.

24. Petitioner underwent a CT scan of the lumbar spine on November 14, 2011. The scan revealed multilevel degenerative disc disease from L1-L4 and that the post-operative lumbar spine status post posterior spinal fixation extending from L4-SI with left neural foraminal narrowing at L4-SI, and questionable spinal nerve root impingement was not definitively excluded. PX.7.

25. Petitioner was seen by Dr. Hayward on November 22, 2011. He was doing extremely well. The CT scan demonstrated some bony growth along the facet joints and around the screws. He was to follow-up in 6-8 months for a repeat CT. Petitioner reported that as of January 1, 2012, he would not be able to afford additional tests due to high copays. It was recommended that he still follow-up. It was noted that Petitioner was a great patient and very compliant with the bone growth stimulator. PX.9.

26. Petitioner testified that he paid $5,000.00 in out-of-pocket expenses in 2011. His group health was cancelled January 1, 2012.

27. Petitioner was seen by Dr. Hayward on June 22, 2012. He was doing extremely well given where he was prior to surgery. He had some complaints of pain, but it was tolerable. He has some limitations on daily activities. The x-rays revealed good placement of the hardware. Petitioner requested a State of Illinois Disability Identification Card, to which Dr. Hayward agreed. He was to follow-up in a year. PX.9.

28. Petitioner's attorney obtained a Section 12 examination from Dr. Kevin Vaught on April 6, 2015. It was noted that Petitioner described two separate occupational injuries on or about December 2010 and January 2011 while carrying and lifting sheetrock at work. The incident involved carrying returned sheetrock out of a customer's home. He has not worked since January 10, 2011. His condition had improved since the surgery. His current pain was 1 out of 10. He opined that petitioner's back condition could have been caused by the lifting incident of December 2010 or early January 2011 as he was not undergoing medical care for an active low back or leg problem prior to the incident. He stated that lifting drywall could cause his condition. He was at MMI as of the date of the letter. He would need permanent restrictions of no lifting over 50 pounds, no repetitive bending, twisting, or lifting, and no overhead work. PX.1.

29. Dr. Vaught authored an addendum on May 1, 2015. He indicated the diagnosis was lumbago, lumbosacral spondylosis, and status post TLIF L4-L5 and L5-SI. The work-related injuries were the cause of his medical treatment and surgery. PX.1.

30. Dr. Vaught was deposed June 29, 2015. He is board certified in neurosurgery and independent medical evaluations. He stated that Petitioner was at MMI as of April 6, 2015. He had 50-pound lifting restrictions. Dr. Vaught opined that the symptoms beginning in December of 2010 or January of 2011 were related to the lifting incidents. PX.2. pg.26. The herniated disc at L3-L4 was the direct result of the work-related injury. The degenerative changes were aggravated by the accident. PX.2. pg.27. He opined that Petitioner cannot return to his prior level of employment. PX.2. pg.29.

31. On cross-examination, Dr. Vaught stated that he has no information of any prior work accidents. His opinions related to the December of 2010 or January of 2011 accident. PX.2. pg.31.

32. Respondent obtained a record review from Dr. Benjamin Crane in September 2015. He did not see any reference to a specific injury at work with the exception of the IME opinion performed by Dr. Vaught. The chiropractic notes failed to state a specific work-related injury for any of the visits. He could not causally relate the low back condition or the need for surgery to a work injury based upon the records.

33. Dr. Crane was deposed October 28, 2015. He is a board certified orthopedic surgeon and performed a records review. He found no evidence of a work injury that would necessitate Petitioner's back pain and need for surgery. RX.2. pg.7. There was no history to which he could relate the low back condition or need for surgery. RX.2. pg.9.

34. On cross-examination, Dr. Crane noted that the mechanism of injury was documented in the medical record a couple weeks following the incident. RX.2. pg.29. Petitioner's symptoms continued without any gaps in treatment from December 2010 through the surgery. RX.2. pg.30. The records document a change in both the type, location and severity of his low back pain after December 2010. RX.2. pg.31. Dr. Crane stated that the lifting incident with the drywall at work could cause back and leg pain. RX.2. pg.34. If Petitioner sustained a work accident, then it could cause his low back condition. *Id.* The mechanism of injury documented by Dr. Cochran could cause or aggravate Petitioner's condition. Dr. Crane stated that he is at somewhat of a disadvantage as he did not take a history directly from Petitioner. RX.2. pg.37.

35. Petitioner testified that he cannot lift over 50 pounds and cannot do any stooping. He has some pain in his leg. T.69. His function is greatly limited. *Id.* He cannot perform his work duties. He last sought medical treatment on June 22, 2012. T.109. He stated that he retired and has not looked for work since his release in June 2012. T.113. He was on disability before that. He has permanent restrictions of no lifting over 50-pounds and he can perform very little bending. His employer never offered to accommodate the restrictions and never offered vocational rehabilitation. T.72.

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).

The Commission disagrees with the Arbitrator's finding that Petitioner is not credible. While the Commission agrees that the Petitioner failed to prove an accident for the first three accident dates, the record does establish that a work accident occurred on December 23, 2010. The delivery slips reveal that Petitioner made a delivery on December 23, 2010 and his testimony relative to the accident was supported by the medical records. The Respondent offered no credible evidence to impeach Petitioner's credibility. In that regard, the Commission finds the Petitioner credible.

While there are discrepancies in the medical records, as to the date of accident, those discrepancies are not determinative of Petitioner's claim. The credible evidence supports that a work-related accident occurred on December 23, 2010. The Petitioner testified that he injured himself while making a delivery on December 23, 2010.

The delivery slips reveal that Petitioner did, in fact, make a delivery on December 23, 2010. Petitioner testified that he then notified Mr. Zoller of the accident and was instructed to take it easy while on his vacation. He attempted to work through his pain upon his return from vacation and only sought treatment once his pain became unbearable. The medical record from January 26, 2011 reveals that Petitioner first had pain while lifting drywall while working. The Respondent chose not to call Mr. Zoller to rebut Petitioner's testimony. Therefore, the Commission finds that the credible evidence establishes that Petitioner sustained an accident arising out of and in the course of his employment on December 23, 2010.

The Commission further finds that Petitioner's condition is causally related to the accident as there is no credible evidence disputing causal connection. Respondent's expert, Dr. Crane testified that the lifting incident as described could cause back and leg pain, and aggravate Petitioner's condition. Dr. Crane further noted that the need for surgery would be related to the accident, if Petitioner did sustain an accident. Dr. Crane's opinion was premised upon there being no accident mentioned in the records. The Commission notes that the medical records, as early as January 2011, reference a work injury. As Petitioner sustained a work-related accident, the Commission finds that Petitioner's condition is causally related to the accident.

The Commission, however, finds that Petitioner reached MMI as of June 22, 2012. It was on this date, that Petitioner last sought medical care with Dr. Hayward. The x-ray revealed good placement of the hardware following the surgery. His complaints were tolerable and he was to

18IWCC0360

follow-up in a year. The Petitioner did not follow-up and did not seek any further medical treatment. Rather, he retired and has not looked for work. The Commission, therefore, awards Petitioner TTD benefits from January 13, 2011, the date Petitioner last worked, through June 22, 2012, the date he last sought medical treatment.

The Commission awards all reasonable and necessary medical expenses as evidenced by the billing records contained in Petitioner's exhibit 12, limited to the lesser of the fee schedule and/or the negotiated rated paid by Respondent's group health carrier. Based upon the stipulation of the parties, Respondent took a credit and Petitioner agreed to same, for all amounts paid by group pursuant to Section 8(j) of the Act.

Petitioner underwent an L4-L5 and L5-SI fusion, an L3-L4 discectomy, and an L2-L3 laminectomy resulting in permanent restrictions. He has not sought medical treatment since June 2012. He had a good recovery and subsequently retired. Accordingly, the Commission finds that Petitioner sustained 25% loss of use of the man-as-a-whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 17, 2017, is hereby reversed for the reasons stated above.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $277.20 per week for a period of 75-2/7 weeks, January 13, 2011 through June 22, 2012, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $249.48 per week for a period of 125 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused 25% loss of use of the man-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses under §8(a) of the Act and subject to the medical fee schedule.

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

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

18IWCC0360

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 8 - 2018

MJB/tdm
O: 4-16-18
052

Michael J. Brennan

Thomas J. Tyrrell

DISSENT

While I concur with the Majority decision affirming case numbers 12 WC 026857, 12 WC 033656 and 13 WC 010928. I respectfully dissent from the decision of the Majority issued under case 13 WC 10931. I would affirm and adopt the Arbitrator's decision. I particularly find the award to be well reasoned, persuasive and that the Arbitrator's findings are grounded in the record. I would affirm the decision in its entirety.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FRED, PAUL S
Employee/Petitioner

Case# **13WC010931**

12WC026843
13WC010760
12WC026857

DuQUOIN HOME LUMBER
Employer/Respondent

18IWCC0360

On 8/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

0693 FEIRICH MAGER GREEN RYAN
D BRIAN SMITH
PO BOX 1570
CARBONDALE, IL 62903

0283 JELLIFFE FERRELL DOERGE ET AL
KELLY R PHELPS
108 E WALNUT PO BOX 406
HARRISBURG, IL 62946-0406

18IWCC0360

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

Paul S. Fred
Employee/Petitioner

v.

DuQuoin Home Lumber
Employer/Respondent

Case # **13 WC 010931**

Consolidated cases: 12 WC 26843, 13 WC 10760, 12 WC 26857

An *Application for Adjustment 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 **June 13, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 23, 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.

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

In the year preceding the injury, Petitioner earned **$21,621.60**; the average weekly wage was **$415.80**.

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

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

Respondent is entitled to a general credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he sustained an accident on December 23, 2010 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being is causally connected to the alleged injury. 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

August 12, 2017
Date

AUG 17 2017

Paul S. Fred v. Du Quoin Home Lumber, 13-WC-010931

Findings of Fact and Conclusions of Law

Petitioner originally had eight claims pending against Respondent. Four of these claims were dismissed at the time of arbitration. The remaining four cases went to arbitration with the parties understanding that separate decisions would issue for each claim. Petitioner's alleged accident date in this claim is December 23, 2010.

The Arbitrator finds:

Petitioner's medical records date back to 2002. On December 4, 2002, Petitioner was seen at DuQuoin Chiropractic Center. Petitioner's Patient Information Form references an injury date of December 2, 2002 which was job-related. (PX 4; RX 3) Petitioner was complaining of neck stiffness and headaches. A history of having been bucked off a horse and left shoulder complaints stemming from "extensive overuse of the left arm" was noted. According to the note, "this all happened about a year ago." Dr. Eaton also noted that Petitioner had occasional back pain described as "crampyness [sic]." (PX 4; RX 3)

Petitioner continued to see Dr. Eaton on six occasions in December of 2002 regarding his left shoulder, left index finger, and mid-back. (PX 4; RX 3)

Petitioner returned to see Dr. Eaton on February 26, 2007, having last been seen there in December of 2002. Petitioner was very sore in the L4-S1 levels and was having difficulty walking, with his symptoms in his low back having been steadily getting worse for the preceding 3 – 4 days. Petitioner continued to see Dr. Eaton in February and March of 2007. Dr. Eaton noted Petitioner's need to periodically sit at work every hour or so and then the pain would stop. Petitioner was also noted to be doing housework and riding his horse, although not very fast. On March 28, 2007 Dr. Eaton noted that Petitioner had been very sore the day before after moving some shingles. (PX 4; RX 3)

Petitioner continued to see Dr. Eaton in April and May of 2007. (PX 4; RX 3) On May 11, 2007, Petitioner reported he was steadily improving and had been very active the previous week. On May 18, 2007, Petitioner reported he was continuing to improve, and that he was performing nearly his normal work duties with only a dull ache. On May 25, 2007, Petitioner reported doing his normal work, which included moving shingles and sheetrock, with very little difficulty.

Petitioner was seen by Dr. Eaton three (3) times in June of 2007 reporting only minimal symptoms consisting of a dull ache on June 1, 8, 22, and July 6, 2007. On July 6th Petitioner reported doing very well and working long days with lots of heavy lifting and experiencing only a dull ache rather than any sharp pain. (PX 4 at 6, RX 3)

On July 16, 2007, Petitioner reported to Dr. Eaton that his low back was very painful after performing heavy lifting. (PX4 at 5). He also reported bilateral leg pain on this date.

Petitioner was seen on July 17, 20, and 24, 2007, complaining of a painful low back. On the 20th he associated his pain with lifting his granddaughter. (PX 4; RX 3)

By July 27, 2007, Dr. Eaton noted Petitioner was doing much better. (PX4 at 5). On August 10, 2007, Petitioner reported only occasional dull aching with no sharp pain despite working very hard at work performing lots of lifting. (PX 4; RX 3)

On September 7, 2007, Petitioner returned to see Dr. Eaton reporting that he was doing very well with only occasional dull aching and no sharp pain. (PX 4; RX 3)

Petitioner was not seen again by Dr. Eaton until September 23, 2008, more than a year following his last visit. (PX4 at 5). Dr. Eaton's note described low back pain beginning approximately three weeks earlier on the left after moving 2x8s at work. He stated the pain dissipated two or three days thereafter with the use of ice, but had returned approximately two weeks earlier to the visit, and included right-sided dull pain radiating to the front side of his leg to his knee. (PX 4; RX 3)

Thereafter Petitioner continued his chiropractic treatment with Dr. Eaton with an additional two visits in September of 2008 and four (4) visits in October of 2008. (PX4 at 4-5; RX 3) As of September 29, 2008, Petitioner felt 90 percent better with an occasional sharp pain when "twisting wrong." During the October visits, Petitioner reported only dull aching or intermittent sharp pain following walking and lifting.

Petitioner returned to see Dr. Eaton on March 8, 2010, having last been seen in October of 2008. Dr. Eaton noted Petitioner had very severe lower back pain and left sacroiliac joint pain. He was having difficulty walking but denied any radiating pain. On March 9, 2010 Dr. Eaton noted no significant change in Petitioner's condition. He still had difficulty walking and sleeping. Dr. Eaton wrote, "He has steadily been getting worse for about 3 weeks but no specific injury to cause it." (RX 4)

Records from Wittenauer Chiropractic, located in Pinckneyville, Illinois, indicate that Petitioner was seen one (1) time for chiropractic treatment on March 30, 2010. (PX5 at 4[1]) According to a general information sheet, Petitioner was there due to neck and back pain. He gave an onset date of "three weeks ago." (RX 4) He denied that the condition was getting worse but indicated that it interfered with his work, sleep, and daily routines. In response to the question "Have you had this or similar conditions in the past?" Petitioner marked "Yes" and noted "Just lower back." (RX 4) When seen by the doctor, Petitioner complained of left sacroiliac and left lower back pain, rating both at 6 out of 10. When asked what aggravated his problem, he responded "it is when he bends and lifts too much." Petitioner also reported that his problems became better when he used NSAIDs and rested. (PX 5 at 4) Petitioner was moderately tender over his left sacroiliac articulation. In the prone position, a functionally short right leg length was noted. An onset date of February 28, 2010 was also noted. (RX 4)

[1] See also RX 4, a copy of Wittenaur Chiropractic records.

According to Respondent's delivery records, on December 1, 2010 Petitioner made deliveries to the old Baptist Church, Searby Funeral Home, DQ High School, and Dave Kent. (RX 7)

According to Respondent's delivery records, on December 2, 2010 Petitioner made deliveries to Jackie Davision, Terry Marks, Brad Galli, John Tilley, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 3, 2010 Petitioner made deliveries to Steve Eisenhauer, McPherson Auto, and Terry Marks (Job – Alongi's). (RX 7; PX 10)

According to Respondent's delivery records, on December 4, 2010 Petitioner made deliveries to Doug Hill, Steve Epplin, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 6, 2010 Petitioner made a delivery to Eric W. (RX 7)

According to Respondent's delivery records, on December 7, 2010 Petitioner made deliveries to Carl Goldman and Dave Kent. (RX 7)

According to Respondent's delivery records, on December 8, 2010, Petitioner made deliveries to Kenny Heape and Pete Daumond. (RX 7)

According to Respondent's delivery records, on December 9, 2010 Petitioner made deliveries to Terry Marks, Gary Dickerson, Joel Tolliver, Steve Eisenhauer, P.C.H.A., Gerald Weeks, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 10, 2010 Petitioner made deliveries to Chris Albers, Steve Eisenhauer, Pinckneyville High School, and Carl Goldman. (RX 7)

According to Respondent's delivery records, on December 13, 2010 Petitioner made a delivery to Tom Denton. (RX 7)

According to Respondent's delivery records, on December 14, 2010 Petitioner made a delivery to Steve Eisenhauer. (RX 7)

According to Respondent's delivery records, on December 15, 2010 Petitioner made deliveries to Carl Goldman and Absolute Construction. (RX 7)

According to Respondent's delivery records, on December 16, 2010 Petitioner made two deliveries to Jackie Davision. (RX 7)

According to Respondent's delivery records, on December 17, 2010 Petitioner made a delivery to Matt Milam, the Elks Club, and Ron Davis. (RX 7)

According to Respondent's delivery records, on December 20, 2010 Petitioner made a delivery to Gene Creek, Chase Porter and Dave Kent. (RX 7)

According to Respondent's delivery records, on December 21, 2010 Petitioner made a delivery to Monte Kuhnert, Carl Goldman, Chase Porter, and Taylor Brothers. (RX 7)

According to Respondent's delivery records, on December 22, 2010 Petitioner made a delivery to "5 - Star." (RX 7)

According to Respondent's delivery records, on December 23, 2010 Petitioner made a delivery to Carl Goldman. (PX 11)

According to Respondent's delivery records, on January 4, 2011 Petitioner made a delivery to Amanda Dearmond, Mark Roznowki, and Graham's Painting. (RX 7)

According to Respondent's delivery records, on January 11, 2011 Petitioner made a delivery to Kellerman's Powder Coat. (RX 7)

On January 13, 2011 Petitioner returned to Wittenauer Chiropractic, having last been seen in March of 2010 and described a "new problem" of right-sided sacroiliac and sciatic pain that he rated at 10 out of 10. Dr. Wittenauer also wrote "The patient's diagnosis from Thursday, December 30, 2010, was amended today." The note also contains a date of onset of December 30, 2010. When asked what made the problem worse, Petitioner responded that "it's worse when he does nothing in particular because it is always there." Petitioner also reported that nothing was relieving his problems. (PX 5; RX 4)

On January 14, 2011, Petitioner returned to Wittenauer Clinic, reporting that he was doing better but also complaining of 9 out of 10 right sacroiliac and right sciatic pain. He underwent chiropractic treatment on that date. Petitioner was advised to return as needed. (PX 5 at 2)

On January 26, 2011, Petitioner was seen by Dr. Douglas Cochran, Tri-County Chiropractic Centre, in Du Quoin, Illinois. (PX3 at 17) Petitioner completed a "New Patient Case History" form. He indicated that his chief complaint was right-sided back pain and pain down his right leg. He claimed his injuries were due to an on-the-job injury but he left the date of accident blank and stated that he didn't intend to turn it in to workers' compensation. (PX 3 at 19) Dr. Cochran noted that Petitioner had been experiencing severe lower back pain and right lower extremity pain for several weeks and had been unable to work for the past two weeks due to his pain. Petitioner stated he first noticed his pain after lifting drywall and that this had happened before but was getting worse. His pain was located in his L3 to S1 region, as well as his right upper anterior thigh. He rated his pain at 8-9 out of 10. Dr. Cochran suspected a lumbar discopathy based upon lumbar x-rays which revealed mild degenerative changes throughout Petitioner's lumbar spine. His physical exam yielded a positive straight leg raise test on the right, positive Lasegue's and Braggard's tests on the right, and right quadriceps weakness. (PX3 at 18) Dr. Cochran assessed Petitioner with lumbar discopathy on this date, which he characterized as a "new condition." (PX3 at 15)

Petitioner returned to Dr. Cochran for four (4) chiropractic treatments in January and February of 2011, before Dr. Cochran referred Petitioner for an MRI of his lumbar spine. (PX3 at 2-14) Petitioner did not return to Dr. Cochran following his MRI. (PX3).

On February 8, 2011, Petitioner underwent a lumbar MRI at Cedar Court Imaging, in Carbondale, Illinois. (PX 3; PX6) The MRI revealed a disc protrusion or mild herniation at L2-3 in the right paracentral region of the spinal canal extending toward the right foramine, resulting in moderate to severe spinal stenosis and right foraminal stenosis. (PX6 at 2) There was asymmetric disc bulging at L3-4 toward the right. At L4-5, there was moderate to prominent left facet arthropathy indenting and compressing the left lateral and left posterolateral aspects of the thecal sac. At L5-S1, there was asymmetric bulging of the disc centrally and posterolaterally toward the left extending into the inferior left foramine. Summarily, Petitioner had evidence of multilevel disc disease with areas of spinal stenosis and foraminal stenosis as noted in the findings.

On February 23, 2011, Petitioner was seen by a physician's assistant at the office of neurosurgeon Dr. Franklin Hayward, Heartland Spine, in Marion, Illinois. (PX9 at 25[2]) Petitioner had been referred by Dr. Furry for his lower back, right hip, and leg pain. According to the note "This started in January 2011." Petitioner had tried conservative treatment but had not experienced any relief. Dr. Hayward's note documented decreased range of motion, paralumbar tenderness, sciatic nerve tenderness on the right, and positive straight leg testing on the right. (PX9 at 25) Dr. Hayward's note also noted decreased sensation in the S1 distribution. Per the MRI, Petitioner was felt to have a disc protrusion asymmetric towards the left along with multilevel disc bulging and degeneration. He noted a disc protrusion at L5-S1 touching the exiting nerve root, and assessed Petitioner with right L5-S1 radiculopathy. He referred Petitioner for an epidural steroid injection.

On March 2, 2011, Petitioner was seen at Southern Illinois Pain Management, Marion, Illinois, by Dr. Julie Sowerby. (PX8 at 8-11; RX 6) Petitioner described his problem as right leg numbness and aching, right foot burning, aching, and numbness and chronic burning and stabbing pain in his lumbar region and right buttock. Petitioner described the aggravating factors as sleep/rest, sitting and walking. In the narrative portion of the report, the doctor stated:

> [Petitioner] has a quite physical job working for a lumber yard. He reports that he has noticed gradually increasing back pain with the work that he does over a number of years. He states that he is a delivery person, and has to lift and move packets of shingles, which are quite heavy. He reports that his back pain began upon awakening from sleep on January 12, 2011. He did not have any new injury or trauma at that time. He does note difficulty performing his job duties due to his low back and leg pain. .....He states that prior to this morning in January when he awakened with pain, he did not have the leg symptoms that he currently has. … (RX 6)

[2] See also RX 5.

Dr. Sowerby noted Petitioner had difficulty with driving, leisure activities, sleeping, standing, walking, working, yard work, lifting and driving a car. Petitioner was diagnosed with facet arthropathy (spondylosis), without myelopathy, low back pain, lumbar degenerative disc disease and spinal stenosis. He was scheduled for an epidural steroid injection. He was also told to continue his Advil and she added Gabapentin. (PX8 at 10; RX 6).

Petitioner underwent an epidural steroid injection at L5-S1 on March 7, 2011, performed by Dr. Paul Juergens at Southern Illinois Pain Management. (PX8 at 7)

On March 22, 2011, Petitioner returned to Southern Illinois Pain Management reporting no relief from his pain, although he felt the numbness and tingling in his right foot was a little better. (PX8 at 5; RX 6)

On March 28, 2011, Petitioner underwent a second epidural steroid injection at L5-S1 slightly to the right of midline. (PX8 at 4)

On April 13, 2011, Petitioner returned to Southern Illinois Pain Management reporting a little relief following the injections, but also describing his condition as worsening. Petitioner told the PA that he would prefer to follow up with Dr. Hayward rather than undergo another injection. (PX8 at 2; RX 6)

On April 27, 2011, Petitioner returned to see Dr. Hayward's PA-C, Chris Hodges. (PX9 at 24) The note documented only temporary relief following injections. Petitioner was noted to have predominantly right lower extremity pain although some prior back pain in previous months had included the left lower extremity. Petitioner reported being unable to work due to discomfort. Petitioner still had sensory changes in the L5 distribution. Petitioner was not able to tolerate his symptoms, and wished to discuss surgical intervention with Dr. Hayward. (PX 9; RX 5)

On May 7, 2011, Petitioner was seen by Dr. Hayward. (PX9 at 23; RX 5) Petitioner's subjective complaints included continuing right leg pain, primarily below the calf and right foot, seemingly in the L5-S1 distribution. Dr. Hayward noted moderate to severe foraminal narrowing at L4-5 and L5-S1 on the left compressing the exiting nerve roots, and Petitioner's greatest areas of foraminal narrowing occurred at L2-3 and L4-5 on the right. Dr. Hayward referred Petitioner for a lumbar myelogram and post myelogram CT, and flexion/extension x-rays of the lumbar spine.

On May 18, 2011, Petitioner underwent a lumbar myelogram and post myelogram CT at Memorial Hospital of Carbondale. (PX7 at 26-27; 30-31) The lumbar CT revealed disc herniations at L2-3 and L3-4 lateralizing to the right, severe degenerative changes to the facet joints at L4-5, and a mild disc bulge at L4-5 as well as minimal anterolisthesis, and a disc bulge at L5-S1. (PX7 at 26-27) Lumbar x-rays from the same date confirmed the presence of spondylolisthesis at L4-5. (PX7 at 28)

On May 25, 2011, Petitioner returned to Dr. Hayward; however, due to a tornado warning, Dr. Hayward was unable to review Petitioner's CT myelogram. (PX9 at 16; RX 5). Dr. Hayward indicated his intent to speak with Petitioner later by telephone. Dr. Hayward noted that Petitioner was walking with an antalgic gait. He documented complaints of severe right leg pain with pain radiating into both the L4-5 and L5-S1 distributions. Dr. Hayward felt Petitioner would probably need a facetectomy with diskectomy, interbody spacer at L4-5, and L5-S1 with instrumentation and SSEP monitoring. (RX 5)

On May 27, 2011, Petitioner was again seen by Dr. Hayward. (PX9 at 15) Dr. Hayward noted the lumbar myelogram showed an L4-5 and L5-S1 right radiculopathy as well as low back pain related to his degeneration and facet arthropathy and neural foraminal stenosis. Petitioner was noted to have bilateral spondylitis at L4-5 and Grade 1 spondylolisthesis at L4-5. Dr. Hayward recommended a transforaminal lumbar interbody fusion at L4-5 and L5-S1 on the right, and decompression and discectomy at L2-3 and L3-4 on the right. Dr. Hayward wrote, "I feel that the patient's Grade 1 spondylolisthesis at L4-5 and disc desiccation at L4-5 and L5-S1 is causing his low back pain." He also noted that Petitioner had a combination of disc/osteophyte complex at multiple levels. Dr. Hayward chose not to perform a fusion at L2-3 and L3-4 due to the risk of adjacent segment disease although he noted a considerable amount of foraminal narrowing due to facet hypertrophy at those levels. (RX 5)

On June 23, 2011, Dr. Hayward performed transforaminal interbody fusions at L4-5 and L5-S1 on the right with laminectomy and discectomy at L3-4 on the right and a laminectomy at L2-3 on the right. (PX9 at 11)

On July 18, 2011 Dr. Eaton issued a note pertaining to Petitioner and his recent back surgery. Dr. Eaton indicated that he had last seen Petitioner on March 11, 2010 and had no knowledge as to his current condition. (PX 4)

On July 22, 2011, Petitioner returned to Dr. Hayward reporting dramatically improved leg and ankle pain. X-rays demonstrated excellent placement of the hardware and spacer. Dr. Hayward referred Petitioner for physical therapy. (PX 9 at 9)

In a note dated August 8, 2011, Dr. Eaton discussed payment of his bills, indicating that Bruce Zoller had paid a total of $600.00 for treatment Petitioner had received from "2-23-12[sic][3] thru 9-7-07." He also wrote that he had treated Petitioner seven times between September 23, 2008 and October 31, 2008 for which Bruce Zoller had paid $188.00. (PX 4)

On September 2, 2011, Petitioner returned to Dr. Hayward, who described Petitioner as "ecstatic" and very pleased with the outcome of his surgery. Petitioner was doing great. He wished to ride his horse but was told not to do so. (PX9 at 7) He was released to drive and instructed to wean out of his brace completely. Petitioner's leg pain was reportedly completely resolved, and Petitioner was no longer taking pain medication. Petitioner declined additional physical therapy and was told to return in twelve weeks for a CT scan.

[3] Should be 2/26/07

On November 14, 2011, Petitioner underwent a CT scan of his lumbar spine, without contrast, performed at Memorial Hospital of Carbondale. (PX7 at 9) The CT scan showed, *inter alia*, questionable spinal nerve root impingement that was not definitively excluded. (PX7 at 10)

On November 22, 2011, Petitioner was seen by Dr. Hayward, who reviewed the CT scan and stated it showed some evidence of bony growth particularly along the facet joints and around the screws, but there was some bone growth within the spacers that was not yet complete. Petitioner described his pain level as a "1" at most. He was noted to be doing extremely well. (PX9 at 4) Dr. Hayward recommended Petitioner return in six to eight months for a repeat CT scan. Dr. Hayward noted that as of January 1, 2012, Petitioner would not be able to afford any additional tests or procedures due to the high co-pay and Dr. Hayward stated he would settle on an x-ray.

On June 22, 2012, Petitioner returned to see Dr. Hayward. (PX9 at 3) Petitioner was reportedly doing extremely well. He had some pain complaints but described them as tolerable. He also reported some limitations with daily activities. X-rays demonstrated good placement of screws and alignment of the lumbar spine. Dr. Hayward recommended Petitioner follow up in one year with a CT scan and flexion/extension films of the lumbar spine, at which point Dr. Hayward stated he would most likely release Petitioner. Petitioner also requested a State of Illinois Disability Identification Card which the doctor signed, indicating Petitioner was at "Class 2." Petitioner did not return to Dr. Vaught's office following this visit. (PX9)

Petitioner has undergone no further medical treatment for his low back since June 22, 2012.

On August 6, 2012, Petitioner's Application for Adjustment of Claim in case #12 WC 26843 was filed. Petitioner alleged an accident date of December 1, 2010 when he was "lifting sheet rock and roofing shingles to customer, Alongi's Restaurant, in the regular course of employment." (AX 2, RX 1)

On August 6, 2012, Petitioner's Application for Adjustment of Claim in case # 12 WC 26857 was filed. Petitioner alleged an accident date of "February 2007" due to "loading and unloading of sheet rock and roofing shingles in the regular course of employment." (AX 4, RX 1)

On September 27, 2012 Petitioner's Application for Adjustment of Claim in case # 12 WC 33621 was filed. Petitioner alleged an accident date of March 1, 2011.[4] (IWCC website)

On September 27, 2012 Petitioner's Application for Adjustment of Claim in case # 12 WC 33656 was filed. Petitioner alleged an accident date of January 12, 2011 due to "repetitive trauma from loading and unloading of sheet rock and roofing shingles in the regular course of employment." (IWCC website; RX 1)

[4] RX 1 contains an unfiled/unnumbered Application for Adjustment of Claim with an accident date of "December 2010." This may be the same claim with injuries being attributed to "loading and unloading of sheet rock and roofing shingles."

On April 2, 2013 Petitioner's Application for Adjustment of Claim in this case (# 13 WC 10760) was filed. Petitioner alleged an accident date of September 2, 2008 while "lifting 2 X 8 pieces of lumber in the regular course of employment." (AX 6; RX 1)

On April 3, 2013 Petitioner's Application for Adjustment of Claim in case # 13 WC 10931 (this case) was filed. Petitioner alleged an accident date of January 4, 2011 due to "lifting in the regular course of employment." (AX 8; RX 1)

On April 3, 2013 Petitioner's Application for Adjustment of Claim in case # 13 WC 10922 was filed. Petitioner alleged an accident date of January 11, 2011 due to "repetitive trauma from loading and unloading building materials in the course of employment." (IWCC website; RX 1)

On April 3, 2013 Petitioner's Application for Adjustment of Claim in case # 13 WC 10928 was filed. Petitioner alleged an accident date of December 7, 2010 due to "repetitive trauma from loading and unloading of sheet rock and other building materials at the residence of customer, Carl Goldman, in the regular course of employment." (IWCC website; RX 1)

Report and Deposition of Dr. Vaught

By letter dated February 12, 2015 Petitioner's attorneys wrote to Dr. Kevin Vaught about the records review he had agreed to perform. The letter referenced all of Petitioner's pending accident dates. Counsel advised Dr. Vaught that it "was their belief" that Petitioner's symptoms were caused or aggravated by two separate incidents while Petitioner was working for Respondent in December of 2010 and/or January of 2011. According to the letter:

> The first injury occurred while [Petitioner] was picking up returned sheet rock from a customer's house. Six or seven sheets were returned. The sheet rock was four by twelve and 5/8 of an inch in width. Each sheet weighed approximately 100 pounds, and the package contained two sheets. [Petitioner] informed us he had to stoop to maneuver the sheet rock through the doorways of the house, and coming out of the house he felt a burning sensation in his low back.
>
> The second injury occurred when [Petitioner] was delivering the same size sheet rock to a restaurant in DuQuoin. [Petitioner] informed us as he was carrying a packet of the same size sheet rock referenced above in to the restaurant with another person. That other person adjusted his hands which twisted the sheet rock and placed greater weight on [Petitioner.] [Petitioner] stated he felt pain in his low back following this incident. (PX 2, Resp. Ex. 1, pp. 1-2)

Dr. Vaught was provided with a brief summary of Petitioner's treatment beginning on January 13, 2011 and advised of Petitioner's history of intermittent chiropractic care for his low back. Records pertaining to all of the foregoing were included. The doctor was further advised that "[b]ased on [Petitioner's] medical history as well as his expected testimony [Petitioner's attorneys] believed [his] low back and leg symptoms as first documented on January 13, 2011 in the records from Wittenauer Chiropractic were caused or aggravated by the incidents at work where [Petitioner] was lifting drywall in the weeks prior to January 13, 2011." (PX 2, Resp. Ex. 1, p. 3)

Petitioner was examined by neurosurgeon Dr. Vaught, Regional Brain & Spine, in Cape Girardeau, Missouri on April 6, 2015.

A written report of the visit followed on/about May 1, 2015. (PX1) In a letter dated May 1, 2015, FNP-BC Debra Alexander (associated with Regional Brain & Spine) issued a cover note regarding the request for an opinion letter on Petitioner. A summary of the consultation note was included. It was noted that Petitioner sought social security disability because he couldn't return to his heavy physical demand labor. Petitioner also denied the need for evaluation or treatment of any lower back symptoms at the time of the exam. Ms. Alexander further noted "My opinions are within a reasonable degree of medical certainty." (PX 1, p. 10)

The consultation note stated that Petitioner gave a history of an onset of symptoms following "two separate work injuries occurring on or about December of 2010 or January of 2011." (PX1 at 1) Both injuries involved carrying sheet rock. Dr. Vaught noted that the first incident involved carrying returned sheet rock out of an individual's home. (PX 1 at 1)

Petitioner described his initial symptoms following his two work accidents as stinging, burning and aching in his lower back, which progressively worsened. (PX1 at 1) He had not worked since January 10, 2011 due to his symptoms. He was treated operatively by Dr. Hayward, and his overall condition improved following lumbar surgery. Dr. Vaught was under the impression Petitioner was unable to return to his heavy physical demand occupation due to work restrictions that had been recommended by Dr. Hayward. (PX 1 at 1)

Dr. Vaught noted Petitioner's subjective complaints on April 6, 2015 included stinging, burning, and aching, which Petitioner modified with his activities. (PX1 at 1) He denied any post-operative complications, and stated he was pleased with his care both before and after surgery. (*Id.*) His pain was rated as 1 out of 10.

Dr. Vaught documented normal motor, sensory, and reflex exams. (PX1 at 3) Range of motion of the lumbar spine was full, and straight leg raise tests were negative. (PX1 at 4)

Dr. Vaught reviewed Petitioner's February 8, 2011 lumbar MRI and stated it showed degenerative disc disease at L2-3 with a small central disc bulge and mild right foraminal narrowing; degenerative disc disease at L3-4 with a broad based disc bulge and a right herniated disc with moderate bilateral foraminal narrowing; degenerative disc disease at L4-5 with a broad based disc bulge and Grade 1 spondylolisthesis and moderate foraminal narrowing; and

degenerative disc disease with moderate foraminal narrowing at L5-S1.The worst foraminal narrowing was on the right at L4-5 and on the left at L5-S1. (PX1 at 4)

Dr. Vaught also reviewed Petitioner's myelogram and post-CT myelogram from May 18, 2011 and Petitioner's lumbar CT scan from November 14, 2011. The May 18, 2011 post-CT myelogram showed a right herniated disc at L2-3, a broad-based disc bulge at L3-4, Grade 1 degenerative spondylolisthesis at L4-5, and a herniated disc at L5-S1 with moderate to severe foraminal stenosis. (PX1 at 5)

Dr. Vaught opined Petitioner's low back and lower extremity symptoms were caused by Petitioner's work accidents. He reasoned that prior to his accidents, Petitioner was not seeking medical care for any active low back or leg problem and Petitioner's mechanism of injury was consistent with the pathology Dr. Vaught observed on Petitioner's diagnostic scans, and was consisted with Petitioner's pre-operative symptoms. (PX1 at 5-6) He felt, certainly, the lifting incidents described by Petitioner aggravated the pathology Dr. Vaught observed on Petitioner's imaging studies. (PX1 at 5). He related the need for Petitioner's treatment, including his lumbar surgery, to his work accidents. (PX1 at 8)

Dr. Vaught believed Petitioner was at maximum medical improvement (MMI) as it related to his work accidents. He placed a permanent 50 pound lifting restriction on Petitioner, with no repetitive bending, twisting or lifting, and no overhead work. (PX1 at 6)

Dr. Vaught was deposed on June 28, 2015. He is a board-certified neurosurgeon and independent medical examiner. (RX2 at 6) Dr. Vaught testified that he examined Petitioner on April 6, 2015 and reviewed his medical records around that same time. He prepared and signed a report containing his findings and conclusions. (RX2 at 7, see also RX1)

Dr. Vaught testified that Petitioner related two separate work accidents occurring in December of 2010 and early in January of 2011. Both involved carrying sheet rock. He testified that the first incident was while Petitioner was carrying sheet rock out of an individual's home and the second incident occurred while Petitioner was taking sheet rock off a forklift at a customer's home. (PX2 at 8) Following the incidents, Petitioner began developing stinging, burning, and aching in his low back, which progressively worsened. These symptoms never resolved on their own. (PX 2 at 9)

Dr. Vaught also testified that Petitioner told him he had experienced intermittent back problems prior to his work accidents. He had previously seen a chiropractor intermittently, but had not recently seen anyone for any actual problems prior to the two 2010 work accidents. (PX2 at 9) Dr. Vaught testified there was no record of any treatment or complaints of either low back or lower extremity pain after March 30, 2010. (PX2 at 23)

Dr. Vaught reviewed the January 13, 2011 note from Wittenauer Chiropractic. (PX2 at 10) Dr. Vaught also testified that the chiropractor noted an onset date of December 30, 2010. Dr. Vaught testified that such a history was consistent with the history provided to him by Petitioner. Petitioner's subjective complaints documented in that note were right sacroiliac articulation and right sciatica, both rated at 10 out of 10. (PX2 at 10) This was described as a new problem.

((PX2 at 10) The documented date of onset in the note was December 30, 2010, which was consistent with the timeframe given by Petitioner on April 6, 2015. (PX2 at 11)

Dr. Vaught also reviewed the March 30, 2010 note from Wittenauer Chiropractic, which was several months prior to the January 13, 2011 visit. (PX2 at 11-12) On that date, Petitioner described left, not right, sacroiliac articulation, and left, not right, lower back pain, and left neck pain. (PX2 at 12) He rated his pain at only 6 out of 10 on that date. (PX2 at 12)

Dr. Vaught further testified concerning his review of Petitioner's medical records from before the 2010 work accidents. (PX2 at 13, 22) According to him, none of those records documented either the type or the severity of the symptoms described in Petitioner's January 13, 2011 record from Wittenauer Chiropractic. (PX2 at 13) Dr. Vaught testified that Dr. Hayward's notation that Petitioner's symptoms began in January of 2011 was consistent with what Petitioner told him. (PX 2 at 16-17) He also testified that Petitioner did not relate to him waking up one morning with back pain (as referenced in the history given at SI Pain Management). (PX 2 at 18) Dr. Vaught felt that none of Petitioner's records from any other provider documented the same severity or type of symptoms as were documented on January 13, 2011. (PX2 at 22)

Dr. Vaught also reviewed Dr. Cochran's January 26, 2011 note. (PX2 at 13) Petitioner's visit was a little more than a week following Petitioner's visit to Wittenauer Chiropractic. (PX2 at 13) Dr. Cochran's note documented severe low back pain and right lower extremity pain for several weeks, which Petitioner first noticed after lifting drywall. (PX2 at 14-15) Dr. Vaught testified this history was consistent with the history given to him by Petitioner on April 6, 2015. (PX2 at 15)

Dr. Vaught reviewed Petitioner's February 8, 2011 lumbar MRI and testified his biggest issue was an L3-4 disc herniation on the right. (PX2 at 15) He also had Grade 1 spondylolisthesis at L4-5, and significant foraminal narrowing at L2-3, L3-4, L4-5, and L5-S1. (PX2 at 15) This pathology was consistent with Petitioner's subjective complaints of pain discussed in the January 13, 2011 record from Wittenauer Chiropractic, and Dr. Cochran's chiropractic records. (PX2 at 15)

Dr. Vaught also testified that the pathology he observed on the lumbar MRI was also consistent with the objective physical findings documented by Dr. Cochran on January 26, 2011. (PX2 at 15) Dr. Vaught testified that Dr. Cochran suspected a radicular problem, which based on the exam and history and MRI, showed findings correlating anatomically to the distribution Dr. Cochran suspected. (PX2 at 15-16)

Dr. Vaught testified that Dr. Hayward's initial treatment record documented Petitioner's symptoms beginning in January of 2011. (PX2 at 16) He felt this was consistent with the timeframe given to Dr. Vaught by Petitioner and Dr. Hayward's documented subjective complaints and objective physical findings were consistent with the pathology observed on the MRI. (PX2 at 16 - 17)

Dr. Vaught also reviewed the records from Southern Illinois Pain Management. (PX2 at 17) The March 2, 2011 note documented complaints of pain, numbness, and aching, as well as

right foot burning, aching, and numbness. (PX2 at 17-18) The note documented Petitioner describing his job duties for Respondent as quite a physical job. (PX2 at 18) Dr. Vaught testified the history of Petitioner's onset of symptoms contained in this note was consistent with what Petitioner told about the two acute events. (PX2 at 18)

According to Dr. Vaught, Petitioner underwent an L4-5 and L5-S1 transforaminal lumbar interbody fusion with instrumentation, then a right L3-4 microdiscectomy and medial facetectomy and foraminotomy, and a right L2-3 laminectomy and foraminotomy. (PX2 at 21) Petitioner did well following surgery. (PX2 at 21)

Dr. Vaught personally met with Petitioner and his wife on April 6, 2015. (PX2 at 25) He took a history from Petitioner and performed a physical exam. His opinions are his own. (PX2 at 25) Dr. Vaught's nurse practitioner, Debra Alexander, assisted with the examination and preparation of Dr. Vaught's report. (PX2 at 24) Dr. Vaught personally reviewed the medical records, and Ms. Alexander acted as a scribe. (PX2 at 24) She translated the handwritten patient form completed by Petitioner[5] into the electronic format, and assisted with obtaining the history from Petitioner. (PX2 at 24) Dr. Vaught routinely has Ms. Alexander assist in the transcription of reports; however, Dr. Vaught reviews all the reports prior to signing. (PX2 at 25)

Dr. Vaught testified that he felt Petitioner was at maximum medical improvement (MMI) and that he needed a permanent 50 pound lifting restriction, as well as restrictions on bending, twisting, and squatting. (PX2 at 25-26) Dr. Vaught causally related the need for these restrictions to Petitioner's work accidents. (PX2 at 28-29)

Dr. Vaught causally related Petitioner's low back and lower extremity symptoms to the two sheet rock lifting incidents Petitioner reported to him. (PX2 at 26) Dr. Vaught testified the disc herniation at L3-4 on the right "was a direct result of that work-related injury." (PX 2 at 27) 27) The degenerative changes were also aggravated, particularly the foraminal stenosis and spondylolisthesis. (PX2 at 27)

Dr. Vaught testified it was significant that Petitioner was not seeking medical care for an active low back or leg problem prior to his work accidents. (PX2 at 27) He also based his opinions on simply talking to Petitioner and hearing him relay the same history. (PX2 at 27) Further, Dr. Vaught based his opinions on the difference in the severity of Petitioner's pain prior to his work accidents and after. (PX2 at 27) The following exchange then occurred:

> Q. The mechanism of injury that [Petitioner] reported to you, was that consistent with causing or aggravating [his] pathology you previously testified to?
>
> A. Yes. Heaving lifting is one of – one of the causes of a herniated disc and aggravating back pain. He also testified that the mechanism of injury, lifting sheet rock, was consistent with a disc herniation and aggravation of preexisting degenerative lumbar conditions.

[5] Not a part of the record.

(PX2 at 28)

Dr. Vaught further testified that Petitioner's treatment, including surgery, was reasonable and necessary to relieve Petitioner of the symptoms the doctor believed were causally related to his work accidents and subsequent treatment. (PX2 at 28)

On cross-examination Dr. Vaught acknowledged that the majority of the records he reviewed were from December of 2010 and onward. He further testified that the records he reviewed pre-dating December of 2010 did not describe a severe radicular pain syndrome consistent with a herniated disc. (PX 2 at 30) Dr. Vaught described Petitioner's pre-December of 2010 complaints of intermittent back pain and sacroiliac joint discomfort as transient in nature. Dr. Vaught further testified that he was not provided with any indication of work accidents prior to December of 2010. Furthermore, he did not recall that the medical records he reviewed related or indicated any work accidents prior to December of 2010. (PX 2 at 31)

Dr. Vaught confirmed on further cross-examination that his causation opinions were related to alleged accidents in either December of 2010 or January of 2011. (PX 2 at 31)

On additional cross-examination Dr. Vaught acknowledged receiving a letter from Petitioner's attorney along with medical records to review. That letter was marked as RX 1 to the deposition. Dr. Vaught acknowledged that the history provided to him regarding Petitioner was contained in that letter and was the same history Petitioner provided to him. (PX 2 at 33-34)

Dr. Vaught agreed that there was no mention in Dr. Wittenauer's January 13, 2011 note of any incident wherein Petitioner's back was hurting after lifting drywall. (PX 2 at 34, 35) He agreed that Dr. Wittenauer's notes reference an onset date of December 30, 2010. (PX 2 at 35) Dr. Vaught also agreed that the doctor's notes from that visit state that nothing in particular aggravated Petitioner's problems because they were always there. (PX 2 at 36) Dr. Vaught agreed there was nothing in Dr. Wittenauer's January 1, 2011 note stating Petitioner hurt his back after lifting drywall. He also agreed that Dr. Hayward's record of February 23, 2011 states Petitioner's low back and right hip pain began in January of 2011. He agreed there was no mention in that office visit of an incident involving the lifting of drywall in December of 2010 or January of 2011. Dr. Vaught also agreed that the SI Pain Management record of March 2, 2011 contains a history wherein Petitioner indicated his back pain began when he woke up on January 12, 2011 and that there was no new injury or trauma. (PX 2 at 36-37)

Dr. Vaught testified that chronic pain is defined as pain in the same distribution or location that occurs for more than six months. He agreed that the DuQuoin Chiropractic records from 2007 indicate Petitioner was getting consistent treatment for severe low back pain for several months. He agreed that the April 6, 2007 entry, while hard to read, suggests Petitioner was having some pain after doing extensive lifting and that on May 25, 2007 he had back pain after moving shingles and sheetrock. He also agreed there are references to heavy lifting and back pain on July 16th and July 27th. Dr. Vaught also agreed that the September 23, 2008 entry states Petitioner was having low back pain that started three weeks earlier on the left after moving two by eights at work and that it dissipated slowly after two to three days but about two week earlier he began having pain on the right side with radiation to the front side of his leg to

the knee. He also agreed that on September 25, 2008 the doctor noted Petitioner's low back was still painful and radiating down around the right leg. He agreed that those records indicated Petitioner had experienced low back pain prior to December of 2010. (PX 2 at 37 -41) Dr. Vaught testified that it appeared Petitioner went to the chiropractor 36 times between February and September of 2007 which he would define as "intermittent" and not constant. (PX 2 at 42)

Dr. Vaught further testified on cross-examination that while Petitioner had low back pain during 2007 he was primarily diagnosed with SI joint dysfunction which is back pain but not mechanical low back pain or radicular pain. (PX 2 at 44) He also acknowledged that the doctor's notes from that time refer to low back pain ("lbp"). When asked how the doctor came up with Petitioner's diagnosis of SI joint dysfunction during that period he testified that he was not the doctor then and did not diagnosis Petitioner with it. (PX 2, p. 46)

Dr. Vaught was asked about the dates of injury provided to him. He testified that he did not have a date for the December injury. It was his understanding that the January date was around January 10th. (PX 2 at 47) He further testified that he knew Petitioner last worked on January 10, 2011. When asked if Petitioner ever gave him a specific date of accident, the doctor replied, "I do not have a specific date. He recalls two specific incidents, which are documented here, but I don't have the specific date." (PX 2, p. 48)

Dr. Vaught was asked about a date of injury "3/1/11" as stated on page one of his report. He testified that it was an error as he didn't know where that date came from. When asked if he had received copies of Petitioner's Applications for Adjustment of Claim (one of which referenced a March 1, 2011 accident) Dr. Vaught replied that he had not. (PX 2, p. 49)

Dr. Vaught reiterated that his causation opinion was based entirely upon the history provided by Petitioner at the time of the examination. He also reiterated that such history was the same one contained in the letter from Petitioner's attorney. (PX 2, p. 50)

Dr. Vaught testified that he performed the focal neurologic examination regarding Petitioner's back and legs and Ms. Alexander did a complete neurological examination. He further testified that there is a "glitch" in his office system which is why it appears the letter to Petitioner's attorney was signed by Ms. Alexander. He reiterated that he performed the examination and not Ms. Alexander. Ms. Alexander assisted him in the preparation of the report; however, he reviewed the report. (PX 2 p. 50 – 58)

On redirect examination Dr. Vaught discussed the histories Petitioner provided to his various treating physicians and chiropractors. (PX2 at 69) He further testified that nothing asked of him on cross-examination would change any of his opinions. (PX 2, 61)

On further cross-examination the following exchange occurred:

> Q. …do you have an opinion within a reasonable degree of medical certainty as to whether or not that gap of almost two years [October of 2008 to October of 2010 or January of 2011] is an indication that the problems that

> he sought treatment for in 2007/2008 is not related to the treatment he subsequently had after December, 2010?
>
> A. It was my opinion that the problems that he sought treatment for after December, 2010 was quantitatively different and consistent with a herniated disc. (PX 2 at 65)

On further cross-examination Dr. Vaught was asked about Dr. Wittenauer's note of January 13, 2011. Based upon what was contained in that note, Dr. Vaught was of the opinion Petitioner, on that date, had a herniated disc causing right sciatica; however, he could not testify to a reasonable degree of medical certainty what specific incident caused that pain. (PX 2 at 66) He also testified that he could not state what specific incident was the cause of Petitioner's complaints at the January 14th visit with Dr. Hayward. (PX 2 at 66-67)

On further redirect examination Dr. Vaught was asked if he ever spoke with Petitioner about the histories he gave to the various providers when they met on April 6, 2015. Dr. Vaught testified that Petitioner told him his main priority when he was first seeking care was to get his pain addressed because it was severe and unlike anything he had experienced previously. (PX2 at 69) Petitioner told Dr. Vaught he used his private insurance and he didn't have work comp coverage. (PX2 at 69) Petitioner told Dr. Vaught he was not setting up any sort of workers' compensation claim, he was merely focusing on his pain. (PX2 at 70)

Report and Deposition of Dr. Crane

After Dr. Vaught's deposition and on/about September 18, 2015 Dr. Benjamin Crane performed a records review for Respondent and issued a report thereafter. In a one-page, undated letter addressed to Respondent's attorney, Kelly Phelps, Dr. Crane stated he reviewed the records provided to him concerning Petitioner. Dr. Crane stated:

> [Petitioner] has been under the care of a chiropractor for quite some time but ultimately ended up under the care of Dr. Vaught when he underwent what sounds like a single level TLIF at the L4-5 level for back pain and possibly leg pain. In reviewing the medical record, I do not see any reference to a specific injury at work, with the exception of the Independent Medical Evaluation and ultimate surgery performed by Dr. Vaught. The chiropractic notes failed to state any significant work-related injury for any of his visits dating all the way back to 2007. (RX 2, dep. ex. B)

Dr. Crane was unable to causally relate Petitioner's low back condition to any specific work accident based upon the history contained in the medical record nor could he causally relate the necessity for Petitioner's surgery in June of 2011 to any specific work accident based on the histories contained in the medical records. (RX 2, dep. ex. B)

Dr. Crane was deposed on October 28, 2015. Dr. Crane testified that he is an orthopedic spine surgeon who was board certified in 2010. (RX2 at 5-6) He testified he performed a medical records review at Respondent's attorney's request. (RX2 at 6) He testified he reviewed records from one of Petitioner's chiropractors, the record from Dr. Vaught, and "some of the care by Dr. Hayward." (RX2 at 6)

Dr. Crane admitted he was at a disadvantage in this case because he did not take a history directly from Petitioner. (RX2 at 36-37) He testified that obtaining a history from a patient is almost the most important thing he does when he meets a patient. (RX2 at 8) Dr. Crane likes to know exactly how the patient hurt themselves, and what situation they were in. (RX2 at 8)

Dr. Crane testified that he could not casually relate Petitioner's symptoms and subsequent surgery in 2011 to his claimed work accident based on his review of Petitioner's records, which he testified contained no indication of a work injury that would necessitate Petitioner's back pain. (RX2 at 7)

Dr. Crane testified his report did not identify any specific records that he may or may not have reviewed, other than Dr. Vaught's report. (RX2 at 14-15) He also testified his report referenced a single, unidentified chiropractor. (RX2 at 15) He conceded that a person reading his report would know only that he read a report from Dr. Vaught and from an unidentified chiropractor. (RX2 at 15)

Dr. Crane also testified that his report stated Petitioner had been under the care of a chiropractor "for quite some time." (RX2 at 16) He explained that this referred to Petitioner's chiropractic treatment by Dr. Eaton at Du Quoin Chiropractic Center. (RX2 at 16) Dr. Crane conceded, however, that these records indicated Petitioner was seen for a few months in 2007, followed by a year-long gap. (RX2 at 17). The records also showed chiropractic care in September and October of 2008, followed by a gap of one year and five months. (RX2 at 16)

Dr. Crane also testified that following the one year and five month gap, Petitioner's records then indicated chiropractic visits in March of 2010. (RX2 at 17-18) He noted that the record from Wittenauer Clinic dated March 30, 2010 documented left sacroiliac articulation and left lower back pain, rated at 6 out of 10. (RX2 at 19)

Dr. Crane agreed there was not another record of treatment with Dr. Wittenauer following the March 30, 2010 visit, and further conceded there was no record of any treatment whatsoever for any condition following March 30, 2010, until after December of 2010. (RX2 at 19-20)

Dr. Crane testified that his Petitioner's chiropractic records from March of 2010 documented left-sided symptoms Petitioner rated at 6 out of 10, but his chiropractic records from January of 2011 documented right-sided symptoms he rated at 10 out of 10. (RX2 at 25-26)

Dr. Crane also testified that his reference to workers' compensation claims came not from Petitioner's medical records, but from Respondent's attorney's letter to Dr. Crane. (RX2 at 15-16)

Dr. Crane testified that he recognized the day before his deposition that he misidentified Petitioner's surgeon in his report. (RX2 at 7) He admitted his report stated Petitioner underwent "what sounds like a single level TLIF at the L4-5 level." (RX2 at 20) He testified he reviewed Dr. Hayward's operative report. (RX2 at 20-21) He conceded Dr. Hayward documented not a one-level lumbar surgery, but a four-level lumbar surgery. (RX2 at 22) He testified his own report was inaccurate. (RX2 at 22)

Dr. Crane testified he reviewed Dr. Vaught's record, which contained histories of two specific instances of Petitioner lifting and carrying sheetrock and materials as part of his employment. (RX2 at 23-24) Dr. Vaught's record also stated Petitioner reported he had not returned to work for Respondent since January 10, 2011 because of his symptoms. (RX2 at 24)

Dr. Crane admitted the history of Petitioner's symptoms documented in Dr. Wittenauer's January 13, 2011 note was consistent with the histories of accident documented in Dr. Vaught's report. (RX2 at 26-27)

Dr. Crane admitted Dr. Cochran's note of January 26, 2011 contained a history of severe low back pain radiating into Petitioner's right lower extremity for several weeks. (RX2 at 27). This was also consistent with the histories of accident documented by Dr. Vaught. (RX2 at 27-28).

Dr. Crane testified the January 26, 2011 note from Dr. Cochran documented a history of first noticing symptoms after lifting drywall. (RX2 at 28) Dr. Crane agreed that this reported mechanism of injury was consistent with the histories contained in Dr. Vaught's record. (RX2 at 28)

When asked whether Dr. Cochran's note from January 26, 2011 that Petitioner's symptoms began after lifting drywall was inconsistent with the statement in his report that there was no reference to an injury at work, Dr. Crane was equivocal. (RX2 at 28-29) He testified that while there was a distinct possibility he was referring to a work accident, the record did not specify a date. (RX2 at 29)

Dr. Crane conceded the mechanism of injury documented by Dr. Cochran on January 26, 2011 was documented a few weeks following Petitioner's alleged work accidents. (RX2 at 30) He further conceded that Petitioner's symptoms continued after December 2010 with no gaps in treatment until he had surgery. (RX 2 at 30) This was consistent with the histories documented by Dr. Vaught. (RX 2 at 30)

Dr. Crane admitted Petitioner always had gaps in his chiropractic care of months or even years prior to his alleged work accident, but there were no gaps following his initial visit to Dr. Wittenaeur on January 13, 2011. (RX2 at 31)

Dr. Crane admitted that if the histories of accident contained in Dr. Vaught's record were correct, then those accidents could have caused Petitioner's back and leg pain. (RX2 at 34) Dr. Crane testified that, to a reasonable degree of medical certainty, if Petitioner suffered the two

work accidents he described to Dr. Vaught in December of 2010, those accidents might or could have caused or aggravated Petitioner's low back condition. (RX2 at 34-35) The mechanism of injury as documented by Dr. Vaught could have caused or aggravated Petitioner's low back condition. (RX2 at 35)

Dr. Crane testified he was not offering any opinion as to the reasonableness and necessity of any of Petitioner's treatment, only that the treatment was not causally related to Petitioner's claimed work accidents. (RX2 at 35-36)

Dr. Crane testified he has been performing independent medical examinations or records reviews on behalf of insurance companies and defense attorneys since he came to St. Louis in 2008. (RX2 at 10-11) Approximately 5 to 10 percent of Dr. Crane's practice is dedicated to IMEs. (RX2 at 11) He testified the legal work he performs is split between plaintiffs and defendants. (RX2 at 12)

The Arbitration Hearing

Petitioner's cases proceeded to arbitration on June 13, 2017. At the time of arbitration Petitioner voluntarily dismissed the following claims: 12 WC 33621; 12 WC 33656; 13 WC 10922; and 13 WC 10928. Respondent was represented by Attorney Phelps in case number 12 WC 26843 and 13 WC 10931. Attorney Hoffman represented Respondent in case number 12 WC 26857 and 13 WC 10760.

At the beginning of the hearing Petitioner moved to amend the date of accident in 12 WC 26843 to December 3, 2010, which was granted. Petitioner also moved to amend the date of accident in 12 WC 26857 to February 23, 2007 which was granted and to amend the date of accident in case 13 WC 10931 to December 23, 2010 which was granted.

With regard to case # 12 WC 26843 (D/A – 12/3/10) the disputed issues were: accident; notice; medical bills; temporary total disability benefits; and nature and extent. (AX 1)

With regard to case # 12 WC 26857 (D/A – 2/23/07) the disputed issues were: accident; notice; causal connection; and nature and extent. (AX 3)

With regard to case # 13 WC 10931 (D/A – 12/23/10) the disputed issues were: accident; notice; causal connection; medical bills; temporary total disability benefits; and nature and extent. (AX 7)

With regard to case # 13 WC 10760 (D/A – 9/2/08) the disputed issues were: accident; notice; causal connection; and nature and extent. (AX 5)

Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he is married and his highest level of education was twelfth grade. Petitioner worked for Respondent approximately sixteen years. He last worked for Respondent on January 12, 2011.

Petitioner testified that he worked for Respondent as a delivery handler. In that position he filled customer orders, consisting of shingles, sheet rock, lumber, windows, doors, concrete, concrete blocks, and any other building materials. Petitioner would get an order off the board, pick up the materials, and deliver them to customers. Petitioner further testified that the shingles he handled and delivered came in packages weighing between 75 and 95 pounds per bundle. Additionally, the sheet rock Petitioner handled and delivered weight approximately 100 to 275 pounds per package, depending on the width of the sheet rock. Petitioner testified that sheet rock was 5/8 inches and 12 feet long and weighed approximately 275 pounds.

Prior to the instant claims, Petitioner had never filed a workers' compensation claim.

Petitioner testified that he sustained a work accident in "February of 2007." He explained that he was pulling material out of a bin to load it on the truck and he heard "something" in his back. He thought it was 2 X 8s, 2 X 10s, or 2 X 12s. When asked what part of his body was affected, Petitioner replied that he didn't know for sure but he "knew" it was the lower part of his back. He rated his pain as a "6/10." He went to Bruce Zoller as he "couldn't do it any longer" and Bruce told him to take it easy and see how he did. Petitioner testified that it kept getting worse and he told Bruce he needed to go to the chiropractor and Bruce told him to go. Petitioner also testified that he received some chiropractic treatment from Dr. Eaton and had to start paying for them. He then approached Bruce and told him that wasn't right because it should be workers' compensation since he was hurt pulling materials out of the bin for him. According to Petitioner, Bruce told him that since he paid his health insurance he wanted to keep it off workers' compensation. Petitioner testified that Bruce and Clarence Zoller own the lumber company. Bruce was his boss. According to Petitioner, Bruce Zoller told him he would speak to Dr. Eaton and that Petitioner should keep treating with him. Petitioner testified that he would have filed a workers' compensation claim if Mr. Zoller hadn't told him otherwise.

Petitioner also testified that Dr. Eaton never recommended an MRI or CT scan following the 2007 accident nor was he referred to a surgeon. Petitioner didn't miss any work after the 2007 incident. He would just take it easy when necessary and then return to his regular duties after he felt his strength returning. After some treatment with Dr. Eaton, Petitioner was able to return to full duty work with no restrictions.

Petitioner further testified that he did not undergo any treatment for his low back between October 31, 2007 and September of 2008. He then sustained another accident while lifting shingles and putting them on the laddervator to deliver to some homeowners. As he was getting down to the bottom of a pallet of shingles, he twisted and felt "something" hurt along with pain in the left side of his lower back. He then returned to see Dr. Eaton, the chiropractor. During this time, Dr. Eaton never recommended an MRI or CT scan nor was he referred to a surgeon. He rated his pain as a "5/10."

Petitioner testified that he told the secretary, Beverly Wisely, and Bruce Zoller about this accident. Mr. Zoller, according to Petitioner, told him he would speak to the doctor and once he was better the company would pay the doctor. He didn't file a workers' compensation claim on this accident for the same reason as the earlier one. Petitioner didn't miss any time from work

because he just reported to work and took it easy when needed. He eventually returned to full duty work without any restrictions.

Petitioner further testified that he didn't undergo any further treatment after the 2008 incident until March of 2010 when he returned to Dr. Eaton; however, he didn't feel any of that treatment was due to a work accident. He also recalled seeing Dr. Wittenauer on March 30, 2010 but thought it was for his shoulder and upper back. When asked if he would disagree with the records if they reflected left-sided sciatic pain, Petitioner replied "No." Petitioner continued working full duty for Respondent during this time and up through December of 2010.

Petitioner testified that on December 3, 2010 he delivered an order to Alongi's Restaurant in Du Quoin, Illinois, consisting of 11 sheets of 4 X 12 5/8 in. sheet rock and 2 x 4s for an addition to the restaurant. He reviewed a work order for this delivery dated December 3, 2010 confirming this delivery. (PX10) Petitioner testified he did not have access to this work order after he was no longer employed by Respondent, and he also did not have access to that work order at the time he filed any of his Applications for Adjustment of Claim. It was not until PX 10, and other, work slips were provided to his attorney that Petitioner had access to this work slip. Petitioner testified that once he reviewed PX 10 and other work tickets, he was able to pinpoint the date of a work-related injury he sustained, which was December 3, 2010.

Petitioner testified that the packets of sheet rock he deliverd to Alongi's weighed approximately 275 pounds per packet. He, an Alongi's employee, and another gentleman were helping Petitioner. Petitioner explained that he had one end of the packet of sheet rock and the employee had it on the other end, but the packet would bow when you picked it up to take it off the forks. When they stood to lift the sheet rock off the fork lift, it jerked, and almost took Petitioner to the ground. Petitioner testified he felt a bad snap in his low back, and felt pain in his low back and right lower extremity following this accident. He rated his pain as 10 out of 10. He also felt a burning and stinging sensation. Petitioner testified that prior to December 3, 2010, he had never experienced symptoms like the ones he experienced after this accident because this time he felt a snap and a burning and stinging sensation. Petitioner testified these symptoms were very different that the ones he had experienced nine months earlier in March of 2010.

Petitioner testified he notified his boss, Bruce Zoller, about this accident. According to Petitioner, Mr. Zoller told him to take it easy and go to the chiropractor. Petitioner testified that he continued to work despite his symptoms, albeit on modified duty. He testified he did not seek immediate treatment, but knew he had vacation coming up between Christmas Day and New Year's Day, and hoped if he took it easy until vacation that his symptoms would improve. He testified his symptoms did not improve.

Petitioner testified that until the Christmas break he continued to work but his symptoms didn't go away. They then recurred on December 23, 2010, when he made a delivery to a customer, Carl Goldman, consisting of 16 4 X 8 by 1/2 in. pieces of sheet rock. After that incident, his symptoms continued to worsen. Petitioner reviewed another work order for this delivery dated December 23, 2010 confirming this delivery (PX11).

Petitioner testified he did not have access to PX 11 after he was no longer employed by Respondent, and further did not have access to PX 11at the time he filed any of his Applications for Adjustment of Claim. It was not until PX 11, and other, work slips were provided to his attorney that Petitioner had access to this work slip.

Petitioner testified that once he was able to review PX 11and other work tickets, he was able to pinpoint the date of a work-related injury he sustained, which was December 23, 2010. (PX11).

Petitioner testified that on December 23, 2010, he was delivering sheet rock to, and picking up returns from, Mr. Goldman's house. According to Petitioner, Mr. Goldman was constructing a new home, and Petitioner was required to duck low to go out from the doorways. Petitioner was carrying three pieces of sheet rock, weighing approximately 75 pounds each, out of Goldman's house. He ducked low to exit a doorway, and felt his low back pop again in the same place as he felt after the incident at Alongi's.

Petitioner testified he had the same pain, stinging, and burning in his low back and right lower extremity as he did following the incident at Alongi's three weeks prior. He rated his pain following this incident as 10 out of 10.

Petitioner testified he notified Mr. Zoller of this accident and Mr. Zoller told him to take it easy, that vacation was coming up, and perhaps Petitioner would get better while off on vacation.

Petitioner testified it was commonly known that Mr. Zoller would not allow injured workers to receive workers' compensation benefits because he paid for their group health insurance. Petitioner testified it was that way for his 16 years of employment.

Petitioner testified his symptoms did not get better during the holiday; rather, they kept getting worse. He testified he attempted to return to work in January of 2011, and worked for around seven days, during which he just sat around as he could hardly do anything.

Petitioner testified that around January 10, 2011, he got up to go to work and could not even bend over to pull his socks up or his shoes on. He called Mr. Zoller and told him about his condition. According to Petitioner, Mr. Zoller told him to just stay home and see if his condition improved. Petitioner testified that his condition did not improve and he was unable to return to work again.

Petitioner was required to seek treatment for his condition. His pain and stinging in the right side of his back and his right leg was so bad he could hardly stand it. He rated his pain as 10 out of 10 at that time.

Petitioner testified that he first sought treatment at Wittenauer Chiropractic in January of 2011. He was experiencing pain in the right side of his back. He also noticed a stinging sensation and right leg pain. When asked if he happened to tell anyone at Wittenauer Chiropractic about his injury he testified that he thought he did but he couldn't swear to it.

Petitioner testified he also saw Dr. Cochran, another chiropractor, in January of 2011. He started paying him and told the doctor it wasn't right that he was paying for the treatment when it happened at work but his employer wouldn't let him proceed under workers' compensation since it provided him with his health insurance. According to Petitioner, Dr. Cochran got hold of Bruce Zoller and he gave Petitioner his money back. From then on the doctor couldn't do anything for him and he referred him to Dr. Hayward.

Petitioner testified when he first came under the care of Dr. Hayward, he saw Dr. Hayward's physician's assistant. He remembered the PA's name was Chris. He testified he told Chris he hurt his back working for Respondent and that it should be processed as a workers' compensation claim, but because of Mr. Zoller's statements and policy concerning injured workers not being entitled to workers' compensation benefits because Respondent provided group health insurance, Petitioner told Chris he was required to process the treatment under his group health insurance.

Petitioner testified that PA Chris was the last medical provider to whom he gave a history of his two work accidents in December of 2010 because of Mr. Zoller's statements. He saw at least three more PAs prior to seeing Dr. Hayward, but did not mention to them or to Dr. Hayward his December 2010 work accidents because of Mr. Zoller's requirement that Petitioner use his group health insurance.

Petitioner was asked if he told Dr. Hayward or any of the PAs about the work accidents at Alongi's and Mr. Goldman's and he replied "no" because he was in so much pain at that time he could hardly stand.

Petitioner testified he underwent lumbar injections at Southern Illinois Pain Management. He testified he did not give anyone at Southern Illinois Pain Management a history of his accident at Alongi's or at Goldman's house. Petitioner did not recall giving a history of his pain beginning on January 12, 2011. He testified January 10, 2011 was the date he could not get his socks on, and testified that pain was continuing pain from the accidents at Alongi's and at Carl Goldman's house. His pain did not begin in January of 2011; rather, his pain got so severe at that time that he could not put his socks or shoes on.

Petitioner testified he eventually underwent lumbar surgery on June 23, 2011 performed by Dr. Hayward. He testified he did fine following surgery. He testified he is unable to lift over 50 pounds, and can hardly do any stooping because of ongoing pain. He still has pain in the same locations in his low back and right leg and his functions are limited greatly due to this pain. Petitioner is unable to perform his job duties for Respondent.

Petitioner testified his group health insurance at the time was an 80/20 plan, requiring him to pay 20 percent of his charges out of pocket. He testified he paid more than $5,000.00 out-of-pocket for medical treatment in 2011.

Petitioner testified he last saw Dr. Hayward in 2012, and had to pay for that visit himself, as he no longer had group health coverage. This included paying for an x-ray of his lumbar

spine. His group health was cancelled as of January 1, 2012. Dr. Hayward wanted to see Petitioner again, and wanted Petitioner to obtain a CT scan or MRI. Petitioner explained he could not afford either of those scans, and Dr. Hayward settled for an x-ray, which was all Petitioner could afford. He has not returned to Dr. Hayward.

Petitioner testified that in 2015 he met with Dr. Kevin Vaught in Cape Girardeau, Missouri. He testified he actually met with Dr. Vaught, not just Dr. Vaught's PA, and that Dr. Vaught actually performed a physical examination on him. Petitioner testified Dr. Vaught placed permanent restrictions on him, and that Respondent never offered to accommodate those restrictions or bring Petitioner back to work. Respondent never offered Petitioner vocational rehabilitation services or any assistance any sort of job search.

Petitioner testified he has never heard of Dr. Benjamin Crane, and that he had never been examined by him.

On cross-examination, Petitioner testified his pain was a "10/10" after he got hurt in early December of 2010. He agreed that he didn't get any treatment but he continued to show up for work. When asked if he actually worked, he replied he did not as he mostly sat around because he could do very little. He denied making any deliveries after December 3rd. He then testified that he started making some deliveries because he guessed the inflammation went down but those deliveries didn't begin until shortly before December 21, 2010. Petitioner then clarified that he didn't think he did for "maybe four to six days." Petitioner was then asked about a delivery of wood boxes to Taylor Brothers on December 21, 2010. He testified he drove the delivery truck to Taylor Brothers, but they unloaded the materials themselves because he was unable to move them.

Petitioner was also asked about a delivery on December 20, 2010 to Dave Kent. He testified Mr. Zoller had the yard boy load the materials on the truck. Petitioner drove the truck to Dave Kent's, and they unloaded the materials.

Petitioner was asked about a delivery on December 16, 2010 to Jackie Davidson. He testified it was the same as the previous question, that Petitioner was able to drive the truck, but was unable to either load or unload the truck.

Petitioner testified he continued to make deliveries, without loading and unloading the truck, until January 10, 2011 when he was unable to return to work due to pain. Prior to January 10, 2011, he would show up every day and would either sit around, and/or sometimes drive the delivery truck, but did not load or unload the truck.

Petitioner reviewed several work orders from December 1, 2010 to January 11, 2011. (RX7). He testified that some of these deliveries were not made by him. The deliveries he made during that period contain his initials at the bottom.

Petitioner confirmed that on December 1, 2010, prior to the Alongi's work accident, he made deliveries to Searby Funeral Home, Heartland Mechanical, and Du Quoin High School.

He also confirmed that on December 2, 2010, also prior to the Alongi's work accident, he made deliveries to Terry Marks, Carl Goldman, and to Brad Galli.

Petitioner testified that deliveries following December 3, 2010 were loaded by Respondent's other employees and unloaded by the customers themselves, as he was unable to load or unload the truck due to his work injury of December 3, 2010.

Petitioner testified that his last day of work for Respondent was January 10, 2011. He was then shown a delivery ticket for January 11th and agreed it had his initials on it but he had no explanation. He thought the 10th was a Tuesday morning and the last day he went in to work. He agreed that the work slips show he continued to work and that he drove the truck and forklift making deliveries. He also agreed that he sought no medical treatment in December of 2010.

Petitioner confirmed on cross-examination that the first time he sought medical treatment following his injuries at Alongi's and at Goldman's house was on January 13, 2011 with chiropractor Dr. James Wittenauer. Dr. Wittenauer's note documented that Petitioner's symptoms were worse when he did nothing because they were always there. Petitioner testified this was true after he was injured. He testified he may have failed to mention his December of 2010 work accidents at that visit, but those accidents were the reason he was there. Petitioner testified the notation in Dr. Wittenauer's records of symptoms beginning December 30, 2010 was inaccurate, and that someone must have written it down wrong.

Petitioner agreed that he underwent chiropractic treatment for left-sided low back pain beginning in February of 2007. Despite an entry in Dr. Eaton's September of 2008 records to the contrary, Petitioner did not believe he had prior right-sided low back pain in September of 2008. He was shown Dr. Eaton's record from September 23, 2008, and conceded the record indicated complaints of right low back and right leg pain, but he testified he recalled his pain being on the left side at that time.

Petitioner also agreed that he underwent chiropractic treatment from February of 2007 until September of 2007. He believed during that time he underwent 28 chiropractic treatments. He also agreed that in September and October of 2008 he underwent seven (7) chiropractic treatments.

On further cross-examination, and contrary to his testimony on direct examination, Petitioner indicated that his treatment in March of 2010 was due to a work accident. He did agree that his complaints in March of 2010 were on his right side. He added, however, that his right-sided complaints began in December of 2010. Petitioner then testified that he didn't remember seeing a chiropractor in March of 2010 as he did not see one until 2011.

Petitioner was shown Dr. Eaton's visits from March of 2010. Petitioner testified that he did not see the doctor at that time. He further testified that there is another "Steve Fred" in DuQuoin and "that was not me." He did agree that he saw Dr. Eaton in October of 2008.

Petitioner testified that Dr. Cochran referred him to Dr. Hayward. When asked about Dr. Hayward's note indicating he was referred by Dr. Furry, Petitioner testified Dr. Furry was his family doctor, but that Dr. Cochran had actually referred him.

Petitioner reiterated that his symptoms began after the two incidents at Alongi's and Goldman's house despite the notation in Dr. Hayward's records that his symptoms began in January of 2011. He testified he did not review Dr. Hayward's records prior to arbitration.

Petitioner reiterated on cross-examination that he told Dr. Hayward's PA Christopher Hodges about his two December of 2010 work accidents despite them not being documented in the initial treatment record of February 23, 2011. He further testified that he may have told the doctor it began in January of 2011 but it really started in December of 2010.

Petitioner testified he was seen at Southern Illinois Pain Management on March 2, 2011. He confirmed the note from this visit stated his symptoms began after awakening from sleep on January 12, 2011 with no new injury, but he testified his symptoms began in December despite what was documented in this record. Petitioner testified the Southern Illinois Pain Management record from March 2, 2011 does not accurately describe what had happened to him.

Petitioner denied that his low back condition simply gradually got worse over time while working for Respondent. He testified that "when something hits you like that and takes you almost to your knees, you know that's when it happened." Petitioner testified he was one of the strongest men who ever worked for Respondent, but following the two incidents in December of 2010, he could not perform his duties anymore.

Petitioner agreed there was no incident or accident that occurred in January of 2011. Petitioner testified that on January 10, 2011 his pain got so bad that he could no longer stand it and could no longer even drive. He again related that pain to the two incidents in December of 2010.

Petitioner testified he saw Dr. Hayward for the last time on June 22, 2012 after he had his lumbar x-ray made. Dr. Hayward's note indicated he would most likely release Petitioner from care after a one-year follow up. Petitioner did not follow up in 2013 with Dr. Hayward because he could not afford it, as his group health insurance had been cancelled.

Petitioner testified he saw Dr. Vaught on the advice of his attorney. Dr. Vaught did not render any treatment, but examined him, and advised him to apply ice every 20 minutes. He saw Dr. Vaught once.

Petitioner testified he has not sought work since retiring in 2016, when he turned 66 and began receiving Social Security benefits. Prior to that, he had received social security disability benefits, but was not a Medicare recipient.

Petitioner testified it was not accurate to say his low back pain developed in 2007 and continued until he quit working in January of 2011. He testified his prior low back pain resolved in 2008.

Petitioner testified he first saw chiropractor Dr. Eaton in 2002 for what he believed to be a shoulder issue. He treated with Dr. Eaton beginning in February of 2007 for a low back condition, during which time he continued to show up to work. He lost no time.

Petitioner testified that at the end of his treatment with Dr. Eaton in 2007, he was released to work full duty with no restrictions. He also testified that his back pain was "completely gone" after 2008. He then did not seek any further treatment until January of 2011.

On further cross-examination Petitioner agreed that he saw Dr. Eaton in for several months in 2007 for left-sided back pain. During that time he continued to work or, as he described it "showed up.' He did not lose any time from work. He was released with no restrictions in 2007.

Petitioner further testified that after another incident he returned to Dr. Eaton in September of 2008. Petitioner again treated with Dr. Eaton approximately seven (7) times from September to October, 2008 for left-sided back pain. After those seven visits, Petitioner quit going to Dr. Eaton because he felt good enough to work full duty without restrictions. He returned to his full duty work at that time. He lost no time following the 2008 work accident.

Petitioner further testified that he had no back problems from October of 2008 until his two work accidents in December of 2010 and his symptoms following those work accidents were right-sided.

On redirect examination Petitioner confirmed that he reviewed the work tickets from December 1, 2010 to January 11, 2011. (RX7) He testified that his initials on a work ticket did not mean that he physically loaded and unloaded materials. He was responsible for making sure the materials on the ticket were delivered. After he was injured on December 3, 2010, he testified that even Mr. Zoller told customers they would be required to unload the materials themselves, and Mr. Zoller had other employees load the materials for Petitioner; however, he could still drive at that point.

Petitioner testified that, assuming he underwent chiropractic treatment in March of 2010, approximately nine months prior to December of 2010, he received no other treatment after March of 2010. He saw no chiropractor, physician, surgeon, or any other medical professional from March of 2010 until after his work accidents at Alongi's and Carl Goldman's house.

Petitioner testified he knew for certain he was injured at Alongi's on December 3, 2010, and at Carl Goldman's house on December 23, 2010. He denied simply picking two dates.

Petitioner was shown an Application for Adjustment of Claim with a date of accident of "December 2010." (RX1; see also AX2). Petitioner testified he could not remember the exact date of this injury until he reviewed the work order tickets. He knew it had been in the month of December.

Petitioner admitted filing other Applications for Adjustment of Claim claiming dates of accident of December 1, 2010, December 7, 2010, January 4, 2011, January 12, 2011, and March 2, 2011. Petitioner testified these were filed before he reviewed the work order tickets.

Petitioner testified that the Application for Adjustment of Claim for Case No. 12-WC-26843, on which the date of accident was amended to December 3, 2010, described an incident lifting sheet rock and roofing shingles to customer Alongi's Restaurant in the regular course of employment. Petitioner testified he had always been able to identify Alongi's Restaurant as the location where he was injured. The work ticket from December 3, 2010 described the same delivery to Alongi's as was described in his Application for Adjustment of Claim. (PX 10)

Petitioner was also shown an Application for Adjustment of Claim with a date of accident December 7, 2010. Petitioner testified that the location of the accident contained in this Application for Adjustment of Claim was Carl Goldman's house. (RX1)

Petitioner testified it was "fair to say" he knew he had been injured at Alongi's and at Goldman's house even prior to reviewing the work tickets. The work order tickets for Alongi's on December 3, 2010, and for Carl Goldman on December 23, 2010, confirmed the actual dates for Petitioner. (PX10; PX11)

Petitioner was asked why he filed so many Applications for Adjustment of Claim if he knew he had been injured at Alongi's and at Goldman's house. Petitioner testified he did not know, and that perhaps it was because his attorney told him to. Regardless, Petitioner testified that once he got the work order tickets, he knew exactly when he had been injured. He always knew where, but the work tickets confirmed when.

The Arbitrator concludes:

Petitioner's Credibility.

At the outset the Arbitrator notes that, initially, Bruce Zoller's absence was troubling given Petitioner's testimony as to comments by him as well as his alleged business practices regarding the handling of work injuries. However, as she reviewed the record and the testimony of Petitioner this became less of a concern as she determined that Petitioner, himself, was not a credible witness and his testimony about Mr. Zoller may have been largely self-serving given the disputed issues of accident and notice in all four of his claims. Furthermore, the take-away from Petitioner's testimony was the suggestion that he didn't want to mention a work accident to any doctors so that his group health would cover the costs per Mr. Zoller's "wishes." However, Petitioner had been working for Respondent for seventeen years. He had mentioned work accident in prior visits (2002 and 2008) and he had told Dr. Sowerby about gradually developing work-related problems.

There were other inconsistencies in, not only Petitioner's testimony on direct examination and cross-examination but between his testimony and what is found in the medical records.

Petitioner testified that he had no right-sided back/leg complaints in September of 2008. Dr. Eaton's records show otherwise. Petitioner acknowledged having some low back treatment in March of 2010 and some right-sided complaints during that time but further claimed they were unrelated to any work accident. He then testified to the contrary on cross-examination as he denied any treatment in March of 2010 whatsoever and further claimed there was another person with the same name as his living in DuQuoin who must have had that treatment; however, no steps were taken to clarify this by affidavit or deposition of the doctor. Furthermore, it seems strange that, if Petitioner didn't treat in March of 2010 as shown by the records, why was Dr. Vaught asked to assume that he did? There was also Dr. Eaton's note of 2011 in which he stated he had last seen Petitioner in March of 2010. Finally, there was Dr. Wittenauer's reference in January of 2011 to having last seen Petitioner in March of 2010. Thus, two of Petitioner's treating doctors acknowledged treating Petitioner in March of 2010 contrary to Petitioner's testimony.

Petitioner presented to Wittenauer Chiropractic on January 13, 2011 with a "new problem" that the doctor attributed to an onset date of December 30, 2010. The doctor also noted that his diagnosis from December 30,2010 needed to be amended. Petitioner, on cross-examination, was asked about the history and testified it was wrong and that someone must have written it down wrong. Petitioner knew accident was in dispute with regard to his claims and, yet, he undertook no effort prior to arbitration to correct a possible scrivener's error or otherwise address what he felt was a mistake. His explanation for the history wasn't persuasive.

A review of Dr. Sowerby's March of 2011 report shows that Petitioner told the doctor he had noticed gradually increasing back pain with the work he had been doing over the years as a delivery person. (RX 6) However, at the hearing Petitioner denied any gradual pain stemming from work duties and he voluntarily dismissed his claims based upon repetitive trauma thereby seeming to contradict any history provided to Dr. Sowerby. Again, another inconsistency.

Another major inconsistency stems from Petitioner's testimony regarding his level of activity at work after the alleged December 3, 2010 accident. Petitioner testified that after his alleged December 3, 2010 accident he was unable to work full duty for Respondent (ie. lift and carry) as his symptoms weren't going away so he worked "modified duty." He testified that he then had another accident on December 23, 2010 while carrying sheet rock out of Carl Goldman's home. On cross-examination Petitioner was asked if he actually worked after December 3rd and he replied that he mostly sat around "because he could do very little." Petitioner also denied making any deliveries after December 3rd but then acknowledged making some deliveries because "he guessed his inflammation had lessened." Petitioner was also asked about a number of delivery tickets bearing his initials. He testified that he only drove the delivery truck and that others loaded and unloaded because he was unable to do so. Petitioner further testified that he only sat around at work or drove the delivery truck and others loaded and unloaded because he was unable to do so. If Petitioner is to be believed regarding his inability to physically do anything for Respondent after December 3, 2010 then his testimony about sustaining another accident on December 23, 2010 is untrue as, by his own testimony, he couldn't have been carrying anything at Carl Goldman's home. Alternatively, if his testimony about his level of activity was not true then he continued to work full duty making deliveries. Either way, Petitioner's believability has been undermined.

Yet another credibility issue surfaced regarding Petitioner's testimony regarding his referral to Dr. Hayward. Petitioner testified that Dr. Cochran referred him to Dr. Hayward. That is not corroborated by Dr. Cochran's records. Furthermore, Dr. Hayward's records indicate "Dr. Furry" (Petitioner's family doctor – see p. 20 of PX 3) was the referring physician (and Dr. Furry received copies of all office notes from Dr. Hayward). Petitioner provided absolutely no testimony as to why Dr. Furry referred him to Dr. Hayward (since he claimed Dr. Cochran did so). Additionally, Dr. Furry's records aren't a part of the record which is troubling since it is clear from Dr. Hayward's records that the referral to a spine surgeon came from him.

Petitioner went into the arbitration hearing knowing that "accident" was an issue in each of his four cases that were going forward. With regard to the alleged accident dates in December of 2010, it wasn't just the date of accident being disputed but also the mechanisms of injury and lack of any real corroboration for either alleged date of accident in Petitioner's treating medical records. Petitioner testified that on December 3, 2010 he was delivering sheet rock to Alongi's restaurant. He testified that he was injured while lifting street rock and that two other people were working with him when it happened (one of which was an employee of Alongi's). Petitioner could have subpoenaed these people or obtained affidavits from them to corroborate his testimony. He didn't and he provided no explanation as to why he couldn't or didn't.

Similarly, Petitioner testified that he wasn't sure if he told Wittenauer Chiropractic about his December 3, 2010 accident. He also testified that he told Dr. Cochran he injured himself at work and that he told Dr. Hayward's PA-C Chris Hodges about hurting his back at work. None of the records of these treaters corroborates Petitioner's testimony. Again, Petitioner could have deposed them to obtain corroboration; however, he didn't.

Further credibility issues come to light upon reviewing Dr. Vaught's consultation exam. Dr. Vaught's report references that Petitioner told him he was unable to return to work for Respondent due to work restrictions recommended by Dr. Hayward. This is untrue as Dr. Hayward's office notes and records fail to mention any permanent restrictions or recommendations. It also appears that Petitioner never advised Dr. Vaught that he never returned to Dr. Hayward for a final release. Petitioner testified that Dr. Vaught recommended he use ice every twenty minutes. There is no corroboration for that within Dr. Vaught's report or deposition. Petitioner's misrepresentations undermine his credibility.

Lastly, the Arbitrator found Petitioner's testimony about his current abilities difficult to believe and contrary to the objective reports and records in evidence. Petitioner's voiced complaints and limitations at trial essentially mirrored those of the permanent restrictions imposed by Petitioner's examining physician, Dr. Vaught. In comparison is the fact Dr. Hayward, when last seeing Petitioner after his surgery, noted Petitioner was doing "extremely well" with tolerable pain complaints at most. He required no medication. Petitioner was to follow up with Dr. Hayward but didn't. There was a gap of three years between Petitioner's last visit with Dr. Hayward and his examination with Dr. Vaught. When examined by Dr. Vaught, Petitioner's physical examination was recorded as normal with only subjective complaints being noted. Dr. Vaught provided no reason as to why the permanent restrictions were necessary. He was, based upon Petitioner's history to him, erroneously under the impression Dr. Hayward had

recommended permanent restrictions. There was no corroboration by any credible objective evidence for Petitioner's testimony regarding any current limitations and difficulties.

Issue C - Did an accident occur on December 23, 2010 that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner failed to prove that he sustained an accident on December 23, 2010 that arose out of and in the course of his employment with Respondent. This conclusion is based upon Petitioner's lack of credibility and the lack of corroboration of an accident having occurred as alleged.

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim, including proof that he suffered an accident which arose out of and in the course of his employment. Nee v. Illinois Workers' Comp. Comm'n, 2015 IL App (1st) 132609WC (1st Dist. 2015). Petitioner failed to meet this burden herein.

First, there is no history of a specific work accident on December 23, 2010 found in Petitioner's medical treatment records. At the time of arbitration Petitioner amended his date of accident from January 4, 2011 to December 23, 2010. Petitioner's medical treatment records contain no mention of an accident date of December 23rd or a description of an incident as testified to by Petitioner.

Petitioner did not seek any medical treatment after December 23, 2010 until January 13, 2011. At that time he gave an onset date of "December 30, 2010". He did not provide any details as to what happened on December 30th or where it occurred. Again, there was no mention of a back injury sustained while carrying material out of a customer's home. Petitioner testified that he wasn't working on December 30th because of the holiday. While he also testified that the date of December 30th had to be an error, he took no steps prior to trial to correct it (again, realizing "accident" was in dispute regarding his claim).

When Petitioner presented to Dr. Cochran at Tri-County Chiropractic on January 26, 2011 he did not mention an accident on December 23, 2010; rather he referenced low back pain for "several weeks." "Several" suggests more than two and less than many (certainly less that eight weeks or almost two months). While Petitioner mentioned lifting drywall he provided no specific details as to time, place, or date. He said nothing about carrying material out of a house. It is also noted that "this had happened before."

Next, Petitioner presented to Dr. Hayward on February 23, 2011 and gave an onset date of "January 2011" with no other details.

When seen by Dr. Sowerby on March 2, 2011 Petitioner gave an onset date of January 12, 2011 when he experienced back pain upon awakening. While Petitioner also described a gradual increase in back pain over the years associated with his work as a delivery person for Respondent, the Arbitrator cannot help but note that of the eight claims filed by Petitioner against Respondent, four alleged a repetitive trauma theory. However, those four claims were

voluntarily dismissed by Petitioner at the beginning of the arbitration hearing. Thus, it appears Petitioner voluntarily abandoned any repetitive trauma theory for his injuries and, as such, it becomes difficult to believe Petitioner's testimony that the symptoms Petitioner experienced on January 10, 2011 were an escalation of any pain beginning on December 23, 2010, especially given his allegation of another accident having occurred on December 3, 2010 (a different claim) from which he allegedly never recovered.

With regard to this particular claim, and as discussed above concerning Petitioner's credibility, Petitioner presented no objective and reliable evidence to corroborate his testimony that he injured himself on December 23, 2010 as he claims. He could have subpoenaed Mr. Goldman but he didn't. Work orders show that Petitioner worked and made deliveries throughout the month of December of 2010 and up to January 11, 2011. While Petitioner attempted to downplay his level of activity at work during those time periods, his testimony (as discussed above) was not credible. Furthermore, while Petitioner testified that this accident was severe and significant he waited three weeks before seeking any medical treatment and then told the doctor the pain began when he woke up the morning of January 12, 2011 and was not precipitated by any injury or trauma. The Arbitrator is aware of Petitioner's contention that he could not tell his doctors about a work accident given the practices of Mr. Zoller; however, as discussed above, given the Arbitrator's concerns about Petitioner's credibility altogether, that testimony is suspicious.

Finally, there is the fact Petitioner could not even get his story straight when being seen by his own examining physician, Dr. Vaught. He told Dr. Vaught he had sustained two accidents – one in December of 2010 and another in January of 2011. Even if one gives Petitioner the benefit of a doubt regarding the problems with recalling the exact dates, he should have been able to ball park them both having occurred in December. More importantly, Dr. Vaught's understanding of Petitioner's second accident was not consistent with what Petitioner testified occurred. Petitioner testified he was carrying sheet rock out of a customer's house and ducked under a doorway and felt his low back pop again. Dr. Vaught's understanding was that the second injury occurred when Petitioner was delivering sheet rock and it twisted resulting in pain in Petitioner's low back. If one solely focuses on the descriptions provided to Dr. Vaught, the first incident is more consistent with what allegedly occurred on December 23rd and the second one is more consistent with what allegedly occurred on December 3rd. Even if Petitioner could not recall the exact dates, he should have been able to recall the general chronological order. Additionally, neither of his descriptions of the accidents included any reference to experiencing a "pop" in his back. Dr. Vaught's descriptions only included reference to Petitioner feeling pain in his back; however, as indicated in many of the medical records, Petitioner purportedly always had back pain.

In summary, with regard to a specific accident having occurred on December 23, 2010, the only evidence supporting Petitioner's claim is his own testimony. Unfortunately, Petitioner failed to present any credible corroborating history to the four doctors he sought treatment from after the alleged incident. He failed to provide any credible corroboration for the accidents themselves. He failed to provide an accurate history to Dr. Vaught.

Petitioner's claim for compensation is denied and no benefits are awarded.

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

Even assuming, arguendo, that Petitioner sustained an accident on December 23, 2010, Petitioner failed to prove that his current condition of ill-being is causally related to that injury.

The only medical testimony offered by Petitioner to establish that his low back condition was causally related to his December 23, 2010 injury was that of Dr. Vaught. Dr. Vaught, however, was not a treating physician. Rather, Dr. Vaught was retained by Petitioner's attorney to examine him. Dr. Vaught's causation opinion, however, was not persuasive. A causation opinion is only as good as the history upon which it was based. Dr. Vaught lacked a complete and accurate understanding of Petitioner's medical treatment and Petitioner misrepresented some of his medical history to the doctor (such as being unable to return to work for Respondent per Dr. Hayward's recommendations). His opinion only took into consideration the history Petitioner gave him when they met. (PX 2, p.26). Dr. Vaught's opinion mirrored the information given to him by Petitioner's attorneys and was based upon the history provided to him by Petitioner which, coincidentally, mirrored what was contained in the engagement letter from Petitioner's attorneys. Dr. Vaught was under the erroneous impression that Petitioner's accidents occurred in December of 2010 and January of 2011. He was also under the erroneous impression that Petitioner first injured his back stooping to carry 100# sheets of sheet rock out of a house and was then re-injured carrying a packed of same-sized sheet rock into a restaurant with another person. Petitioner testified to two accidents in December and occurring in the opposite order. He also testified that the sheet rock was being delivered by forklift and that the alleged accident occurred while picking up the packets off the forklift with another person. Contrary to Dr. Vaught's understanding, Petitioner wasn't carrying anything. Dr. Vaught also could not causally relate Petitioner's low back condition to a specific work accident when he considered the various histories contained in the medical records. (PX 2, p.66-68). Dr. Vaught was also unaware that at the time he examined Petitioner, Petitioner was also claiming repetitive trauma injuries to his back. Finally, Dr. Vaught's testimony that the history provided to him by Petitioner regarding his accidents was consistent with what was contained in the various (and differing) histories of other doctors was simply not believable given the totality of the medical treatment records herein.

Petitioner failed to meet his burden of proof that his current condition of ill-being is causally related to his alleged accident of December 23, 2010. Petitioner's claim for compensation is denied.

Issue "E" Was timely notice of accident given to Respondent?

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"—TTD

6. Issue "L"—What is the nature and extent of the injury?

Given the Arbitrator's determinations regarding accident and causation as set forth herein, the remaining issues ("E", "J", "K", and "L") are rendered moot.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

Debra Rohman,
Petitioner,

vs. NO: 10 WC 34609

18IWCC0361

State of Illinois,
Department of Financial and Professional Regulation ,
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 of Petitioner's permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 2, 2017 is hereby affirmed and adopted.

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JUN 8 – 2018

o-06/05/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROHMAN, DEBRA
Employee/Petitioner

Case# **10WC034609**

STATE OF ILLINOIS-IDPR
Employer/Respondent

18IWCC0361

On 10/2/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0333 SHAY & ASSOCIATES
TIMOTHY M SHAY
1030 DURKIN DR
SPRINGFIELD, IL 62704

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

4993 ASSISTANT ATTORNEY GENERAL
CHELSEA GRUBB
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

OCT 2 - 2017

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Debra Rohman
Employee/Petitioner

v.

State of Illinois-IDPR
Employer/Respondent

Case # **10** WC **034609**

Consolidated cases: **N/A**

18IWCC0361

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 **Springfield**, on **August 29, 2017**. By stipulation, the parties agree:

On the date of accident, **August 5, 2010**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$44,733.00**, and the average weekly wage was **$860.25**.

At the time of injury, Petitioner was **57** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent, and Respondent agrees to pay the outstanding bill owed to Springfield Clinic in the amount of $120.00 and marked as Petitioner's Exhibit No. 4, subject to the Medical Fee Schedule.

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

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

ORDER

Respondent shall pay Petitioner the sum of $**516.15**/week for a further period of **15.375** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **7.5% loss of use of the right hand.**

Respondent shall pay Petitioner compensation that has accrued from **7/07/16** through **8/29/17**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

September 25, 2017
Date

OCT 2 - 2017

FINDINGS OF FACT and CONCLUSIONS OF LAW

Regarding the nature and extent of Petitioner's injury the Arbitrator finds as follows:

As of August 5, 2010, Petitioner was employed by the Department of Financial and Professional Regulation. At that time she was an Office Coordinator and her job required her to sit at a cubical for 6-8 hours a day typing and speaking on a telephone. Petitioner filed an Application for Adjustment of Claim alleging injuries to her neck and right arm with a manifestation date of August 5, 2010.

This matter was initially arbitrated before William Gallagher on November 19, 2014 and a Decision was entered on January 21, 2015. At that time, Arbitrator Gallagher found Petitioner had sustained a work-related injury to her right hand resulting in carpal tunnel syndrome. The Arbitrator denied Petitioner's claim for a neck injury. Arbitrator Gallagher ordered payment of reasonable and necessary medical expenses for treatment of Petitioner's right hand and payment by Respondent for the prospective medical treatment being recommended by Dr. Mark Greatting, including a right carpal tunnel release. (See PX 1)

On February 23, 2016, the Commission affirmed the Decision of Arbitrator Gallagher. (PX 2)

Petitioner returned to see Dr. Greatting on July 7, 2016 in follow up for her bilateral carpal tunnel syndrome. (PX 3) Dr. Greatting had last seen Petitioner on December 19, 2013 at which point she had elected to not proceed with surgery and just observe how she did; however, he also noted that he would recommend surgery if they worsened. In conjunction with the visit Petitioner completed the Brigham and Women's Hospital Hand Symptom Severity Scale & Function Status Scale. For the preceding two weeks, Petitioner described moderate pain in her right hand that would awaken her two to three times at night. Petitioner further described her pain as moderate during the day but constant. She also described her numbness, weakness, and tingling in her hand as moderate. Petitioner reported moderate difficulty with grasping and use of small objects (such as keys and pens), writing, buttoning clothes, holding a book while reading, gripping a telephone handle, household chores, carrying grocery bags, and bathing and dressing. She reported severe difficulty opening jars. (PX 3)

According to Dr. Greatting, Petitioner now reported constant right hand numbness in the radial 3 ½ digits of her right hand with intermittent numbness and tingling in her left hand although primarily in the index finger although the other fingers innervated by the median nerve "sometimes" bothered her. On examination, Petitioner had diminished sensation to light touch in the median nerve distribution of her right hand. Light touch sensation was intact bilaterally. Petitioner also had good strength without weakness or atrophy in the radial, median and ulnar nerve distributions. Petitioner had a positive Tinel's, compression and Phalen's Test over her right carpal tunnel. She had a positive Tinel's and compression test on the left side. Dr. Greatting recommended a right carpal tunnel release based upon the severity of Petitioner's symptoms. Petitioner reported she was working on obtaining workers' compensation approval for the procedure. (PX 3)

Petitioner has had no further follow-up visits with Dr. Greatting nor did she undergo the surgery.

Petitioner's case proceeded to arbitration on August 29th, 2017 with the only disputed issue being the nature and extent of Petitioner's right carpal tunnel injury. Petitioner was the sole witness testifying at the hearing.

Petitioner is currently 64 years old.

Petitioner testified that she did not elect to proceed with the surgery given the risks associated with it.

Petitioner further testified that she continues to work for the State of Illinois in a clerical position with significant typing. Petitioner is right-hand dominant and uses a mouse with her right hand. Petitioner continues to have similar symptoms of numbness and tingling in her right hand that are worse during the work week. Petitioner testified that she uses a homeopathic cream, Traumeel, as recommended by her occupational therapist. Petitioner acknowledged that she did not discuss the use of the cream with Dr. Greatting or any other doctor. Petitioner testified that the Traumeel provides some minimal relief.

Petitioner testified that she experiences pain every day and that it is difficult to pick up little things and she occasionally drops things.

Petitioner also testified that she has been employed in clerical positions since her high school graduation. Petitioner did not go past high school in educational endeavors. She currently has a different job with the State and is earning more money and continuing to engage in significant typing.

Respondent's Exhibits 1 – 4 consist of CMS Summary of Disability information, a CMS Position Description and Demands of the Job Form, Performance Reviews on Petitioner, and Salary Information for Petitioner.

Regarding the nature and extent of Petitioner's injury, the Arbitrator concludes:

This case falls before the amendments to the Workers' Compensation Act of September 2011.

Petitioner has been diagnosed with right carpal tunnel syndrome. She is right hand dominant and has chosen not to pursue surgery at this time. Petitioner's credible testimony as to her ongoing difficulties and symptoms was corroborated by Dr. Greatting's medical records, including his office note of July 7, 2016 and the Brigham and Women's Hospital Hand Symptom Severity Scale & Function Status Scale completed by Petitioner. Respondent did not elect to have Petitioner examined by a physician of its choosing.

The Arbitrator finds that Petitioner has sustained permanent partial disability to the extent of 7.5% of her right hand. Therefore, Respondent shall pay Petitioner the sum of $516.15 per week

for a further period of 15.375 weeks as provided in Section 8(e) of the Act because the injuries sustained caused 7.5% loss of use of the right hand.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Craig Kamp,
Petitioner,

vs. NO: 16 WC 27664

18IWCC0362

Gateway Packaging Co.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review, under Section 19b, having been filed by the Petitioner herein and notice given to all parties, the Commission, accident, temporary total disability, medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 19, 2017, is hereby affirmed and adopted.

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

The party commencing the 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 - 2018

Joshua D. Luskin

L. Elizabeth Coppoletti

Charles J. DeVriendt

o-06/05/18
jdl/wj
68

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

KAMP, CRAIG
Employee/Petitioner

Case# **16WC027664**

GRANITE CITY PACKAGING CO
Employer/Respondent

18IWCC0362

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

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

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

5983 CARAWAY FISHER & BROOMBAUGH PC
JASON CARAWAY
9423 W MAIN ST
BELLEVILLE, IL 62223-1712

0560 WIEDNER & McAULIFFE LTD
MATTHEW J ROKUSEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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)

Craig Kamp
Employee/Petitioner

v.

Gateway Packaging Co.
Employer/Respondent

18IWCC0362

Case # 16 WC 27664
Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **May 8, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **June 26, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Per the stipulation of the parties, Petitioner's average weekly wage was **$1,209.20.**

On the date of accident, Petitioner was **41** years of age, ***single*** with **1** dependent child.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$7,997.00** for non-occupational indemnity disability benefits, for a total credit of **$7,997.00.**

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

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent and, as such, all benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$7,997.00** for non-occupational indemnity disability benefits, for a total credit of **$7,997.00.**

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

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

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

Signature of Arbitrator

6/14/17
Date

ICArbDec19(b)

JUN 19 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Craig Kamp
Employee/Petitioner

Case # **16** WC **27664**

v.

Consolidated cases: **N/A**

Gateway Packaging Co.
Employer/Respondent

18IWCC0362

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he worked for Respondent as a pressman in the flexograph printing or "flexo" department. He testified that on June 26, 2016, he was carrying a sleeve that weighed approximately 100 pounds and felt that he "tweaked" a muscle in his back. He testified that this accident occurred at the end of his shift and that he was able to leave the premises without difficulty. He admitted that he did not report the accident to his employer on that date, but alleged that he told "Lisa" an ex-girlfriend. The Arbitrator notes that "Lisa" was not called as a witness at trial.

Petitioner testified that he was off work the next day, which was June 27th. He testified that on that day, he felt a little pain in his back but thought it was due to a "tweaked" muscle. He testified that that on Tuesday, June 28, 2016, he went out for a drive with Lisa and had to walk a "half mile" back to his home after the car had a flat tire. He testified that he and a buddy of his changed the tire, but on cross-examination later testified that he only watched. He testified that on June 28th later that evening, he went to take a shower. He testified that when he took off his shorts, he felt a severe pain in his back and could not step out of the shower.

Petitioner testified that he subsequently reported a work injury to his supervisor, Ray Byrd. Respondent introduced an e-mail from Mr. Byrd dated July 8, 2016, which indicated that Petitioner called on Wednesday, June 29, 2016, reporting that when he "got out of the shower he bent over to pull up his pants and a pain shot through his back down through his leg." (RX6). In the email, Mr. Byrd further reported speaking to Petitioner later that night and again on Monday, July 4, 2016, at which time Petitioner wanted to start FMLA. (RX6). In the email, Mr. Byrd directed Petitioner to "Barbi" in human resources to complete the paperwork. In the email, Mr. Byrd noted that he spoke with Petitioner again at 11:30 am on July 8, 2016, at which time he "said he wants me to fill out a accident report for him hurting his back lifting Bridges, Plate Sleeves and Aniloxes." (RX6).

Petitioner testified that that he was aware of the company policy about needing to fill out an accident report. He testified that he had filled out accident reports prior to this date of accident for another unrelated accident. He testified that he did not fill out an accident report because he thought he only tweaked a muscle and thought it would be fine the next day. He testified that he talked to Barb Henry about filling out a report and that she was supposed to send one home with Lisa, but she never did.

Barbara Henry was called as a witness by Respondent at the time of arbitration. Ms. Henry testified that she is the human resources manager for Gateway Packaging Company and is familiar with

Petitioner and Lisa Jones. She testified that she first learned of Petitioner's accident via an e-mail from Ray Byrd and that Lisa also came to her office and requested FMLA paperwork. She testified that the e-mail from Mr. Byrd was dated July 28, 2016. She testified that she met with Petitioner on July 5, 2016 when he came to her office and picked up paperwork for short-term disability and FMLA. She testified that when Petitioner came in pick up the paperwork, he did not report a work injury to her. She testified that Petitioner indicated that the accident occurred at home in the shower. She testified that she later became aware of the alleged work injury.

Ms. Henry testified that she was included on the e-mail from Ray Byrd on July 8, 2016 and that prior to that time, she was not aware of any alleged work-related injury. She testified that she conducted an investigation following the allegation of a work-related injury and that she found no paperwork or accident reports that suggested there was a work-related injury. She testified that she did give Lisa the worker's compensation paperwork and that she asked her to have Petitioner call her before he completed it as she wanted to make sure that he understood that if he took that benefit, he would probably not get short-term disability. She testified that she never received the paperwork completed by Petitioner. She testified that she gave it to Lisa rather than Petitioner because he left a voice mail message requesting it.

On cross examination, Ms. Henry agreed that an injured worker who is out of work can also fill out FLMA paperwork. She agreed that she received Petitioner's short-term disability paperwork back. She agreed that the paperwork she received indicated that Petitioner alleged that he hurt himself at work on June 26th.

Bob Tiepelman was called as a witness by Respondent at the time of arbitration. He testified that he is a production manager. He testified that he first learned of Petitioner's alleged injury when Ray Byrd called and that he indicated that he gave Mr. Byrd the direction to call HR. He testified that Petitioner did not talk to him directly about the allegations of his claim.

Mr. Tiepelman testified identified the video of Petitioner leaving the plant on June 26, 2016, which was entered into evidence at the time of arbitration as Respondent's Exhibit 7. He testified that in reviewing the video, he did not see any evidence of an apparent injury.

The medical records of Dr. David Peter were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on July 1, 2016, at which time it was noted that he reported left lower back pain with radiation to the right groin and right leg. The duration was noted to be that of 1-2 days and it was noted that Petitioner denied any trauma. The assessment was noted to be that of low back pain. Petitioner was prescribed medications. The Arbitrator notes that no work slips were included in the medical records. (PX1).

The medical records of Barnes-Jewish St. Peters Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen in the Emergency Department on July 1, 2016, at which time it was noted that he complained of low back pain for the past couple of days with numbness to his legs. It was noted that Petitioner presented with a complaint of low back pain with radiation to the left lower extremity under the History of Present Illness. It was noted that the pain had been present for the past 4-5 days and had been worsening over the past day. It was noted that Petitioner was seen by Dr. David Peter for the first time on that date and was prescribed pain medication. It was noted that Petitioner stated that he was there because he wanted to know what was wrong. It was noted that the pain was in his low back with radiation into his posterior thigh crossing his knee into his calf and that the pain was worse with palpation. It was noted that Petitioner stated that the pain first began when he was leaning forward to getting to the shower. It was noted that Petitioner denied any recent trauma or other difficulty and that he had some intermittent numbness to his bilateral lower extremities. The interpretive report for a CT of the lumbar spine performed on that date noted that the films were interpreted as revealing (1) broad-based disc bulge with superimposed left foraminal disc

protrusion at L4-L5 which severely narrows the neural foramen and compresses the exiting left L4 nerve root; correlate for radicular symptoms corresponding to this nerve root distribution; (2) no acute lumbar spine fractures; (3) mild multilevel degenerative disc disease of the lower thoracic levels; small disc bulges are seen at L3-L4 and L5-S1 with mild bilateral foraminal stenosis at these levels; (4) tiny non-obstructing left nephrolithiasis. The diagnosis was noted to be that of herniated intervertebral disc of the lumbar spine. Petitioner was given prescriptions, was discharged home and was instructed to follow-up with Dr. Piper for reevaluation. The Arbitrator notes that no work slips were included in the medical records. (PX2).

The medical records of Piper Spine Care were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on July 5, 2016, at which time it was noted that he gave a history of getting out of the shower on Tuesday, bending over and feeling a sharp pain in the left part of his buttock radiating into his testicle, not down into the leg, in an L4 even a partially L5 distribution. It was noted that Petitioner was seen by his primary care physician on Friday and that later that night he was seen in the Emergency Department due to worsening of pain. It was noted that a subsequent CT scan demonstrated a disc protrusion at L4-5 to the left involving the neuroforamina as well as part of L4 and partly L5 nerve root. It was noted that the diagnosis was that of left lumbar radiculopathy and that the differential included herniated disc versus neuroforaminal stenosis. Petitioner was recommended to undergo an MRI of the lumbar spine. A work slip was issued on that date, indicating that Petitioner was unable to work. The Orthopedic History form which was signed by Petitioner on July 5, 2016 noted that the problem started on Tuesday and that the problem started when getting in the shower. (PX3).

The records of Piper Spine Care reflect that Petitioner was seen on July 15, 2016, at which time it was noted that he was seen in follow-up after the MRI. The records reflect that no specific information was provided as to the diagnosis or treatment recommendations at that time, but a work slip was apparently issued on that date indicating that Petitioner was unable to work. Petitioner was also recommended to undergo physical therapy. At the time of the July 27, 2016 visit, it was noted that Petitioner's lateral anterior thigh, some intermittent groin pain and medial calf pain was improved. It was noted that some days were better than others but he seemed like he had plateaued since the last visit. The assessment was noted to be that of disc herniation L4-5 cephalad migration with L4 involvement left. It was noted that a selective nerve root block on the left at L4 versus lumbar discectomy were discussed and that Petitioner indicated that he wanted to discuss his options with his family and call back as to how he wanted to proceed. A work slip was issued on that date, indicating that Petitioner was unable to work. At the time of the August 22, 2016 visit, it was noted that Petitioner overall was improved to about 70-75% from his initial visit but that he still had some discomfort in the anterior lateral aspect of the left hip. It was noted that therapy had definitely helped as had the injections he had undergone. The assessment was noted to be that of herniated nucleus pulposus L4-5 cephalad. It was noted that overall Petitioner seemed to be improving and he had no focal motor deficits. Petitioner was instructed to continue physical therapy. A work slip was issued on that date, indicating that Petitioner was unable to work. (PX3).

The records of Piper Spine Care reflect that Petitioner was seen on September 13, 2016, at which time it was noted that he was significantly improved from the index visit and that he had a lot less of the lumbar radicular component. It was noted that Petitioner still had some degree of left buttock and hip pain. It was noted that Petitioner was substantially improve but still had occasions when he bent or lifted and felt a sharp twinge in the left lower back and buttock region. Petitioner was instructed to continue conservative modalities. It was noted that he was scheduled for a midline epidural steroid injection at L4-5 on that date. A work slip was issued on that date, indicating that Petitioner was unable to work. (PX3).

The medical records of Millenium Pain Management were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on August 12, 2016, at which time it was noted that he was seen for back pain. The assessment was noted to be that of (1)

radiculopathy, lumbar region; (2) other intervertebral disc displacement, lumbar region. Petitioner underwent a left L4 transforaminal epidural steroid injection on that date. It was noted that Petitioner had a great deal of L4 radicular pain and that he had also been involved in a car accident and was believed to have possibly fractured his ribs. At the time of the September 13, 2016 visit, it was noted that Petitioner had back pain into the left hip. Petitioner underwent an L4-5 translaminar epidural steroid injection on that date. (PX4).

The medical records of Excel Sports & Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent physical therapy for the timeframe of July 19, 2016 through October 5, 2016. The Additional Liability Information form which was signed by Petitioner on July 19, 2016 did not note that the injury was work-related. At the time of the June 19, 2016 visit, it was noted that Petitioner was simply removing a pair of shorts when the onset of low back pain occurred. It was noted that Petitioner complained of left lower back pain radiating into the left lower extremity and lateral left leg and that he complained of left testicle pain. At the time of the August 1, 2016 visit, it was noted that Petitioner had been seen for a total of five visits with two cancellations/no-shows. At the time of the August 11, 2016 visit, it was noted that Petitioner had been involved in an MVA earlier in the week and had "rib pain" and did not think he could tolerate the traction. At the time of the August 25, 2016 visit, it was noted that Petitioner stated that overall his back was improving and that he noted increased discomfort which radiated into his leg with sustained standing. At the time of the August 30, 2016 visit, it was noted that Petitioner stated that his back was doing better and that he still noted discomfort in his left hip with bending forward and tingling/numbness down his leg when standing in certain positions. At the time of the September 13, 2016 visit, it was noted that Petitioner had no new complaints and stated that he had not been having pain down into his leg. At the time of the September 27, 2016 visit, it was noted that Petitioner had continued improvement and that he stated that he was pain-free over the weekend with only an occasional episode of paresthesia in his hip which resolved when he changed positions. (PX5).

The medical records of Dr. Matthew Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on October 11, 2016, at which time it was noted that he was referred by Terry Piper and presented with a chief complaint of low back pain to the left side, left buttock, left hip and down the left leg to his anterolateral calf with tingling. It was noted that Petitioner stated that his problem began on June 26, 2016 and was lifting large sleeves of material. It was noted that Petitioner was lifting a 35-inch sleeve and felt pain in his back, that he stated that he knew exactly when it happened and that he did not report it as he often had pain in his arms and back but that this was different. It was noted that Petitioner stated that two days later he was doing simple household activities, bent to get into the shower to take his shorts off and had severe sudden pain. It was noted that Petitioner's symptoms were constant and that he felt that it was getting better. It was noted that Petitioner's pain was worse with bending, lifting or prolonged sitting and was better with a change in position. It was noted that Petitioner had left leg pain, denied right leg pain and had numbness. It was noted that assuming the history was factually correct, Dr. Gornet believed that his current symptoms were causally connected to the work activity as described. It was noted that Dr. Gornet recommended further conservative care and that he took him Petitioner work so that he could complete his physical therapy. It was noted that Petitioner's disc fragment would probably resolve on its own. A work slip was issued on that date, indicating that Petitioner was unable to work October 11, 2016 through October 25, 2016. (PX6).

The records of Dr. Gornet reflect that Petitioner was seen on December 15, 2016, at which time it was noted that Dr. Gornet recommended a new MRI scan and surgery which would consist of a microdiscectomy left L4-5. It was noted that Petitioner remained temporarily totally disabled, but no work slip was issued on that date. At the time of the February 27, 2017 visit, no physical examination notations were made by Dr. Gornet. It was noted that given that Petitioner's leg pain was improving. Dr.

Gornet recommended more aggressive work hardening and conditioning and that if Petitioner failed that, consideration could be given to further surgery. It was noted that if Petitioner failed further conditioning, Dr. Gornet would consider discography and/or MRI spectroscopy and potential disc replacement surgery at L4-5. (PX6).

The medical records of MRI Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent an MRI of the lumbar spine on February 27, 2017, which was interpreted as revealing central-left foraminal L4-5 and left foraminal L3-4 disc protrusions with a left foraminal annular tear visible at L4-5 on the sagittal T12 weighted and STIR images; moderate left greater than right L4-5 and mild left L3-4 foraminal stenoses are present but there is no central canal stenosis. (PX7).

The medical records of St. Luke's were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner underwent an MRI of the lumbar spine on July 8, 2016, which was interpreted as revealing (1) L4-5 disc bulging with a left paracentral and foraminal disc herniation with cephalad migration, severe left foraminal stenosis and impingement on the exiting left L4 nerve root; (2) L4-5 small right foraminal and extraforaminal disc protrusion slightly contacting the exiting right L4 nerve root without impingement on the right. (PX8).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibits 9a through 9h.

The medical records of Piper Spinal Care were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records were effectively duplicative of those as contained in Petitioner's Exhibit 3. (RX3; PX3).

The medical records of Excel Sports & Physical Therapy were entered into evidence at the time of arbitration as Respondent's Exhibit 5. The records were effectively duplicative of those as contained in Petitioner's Exhibit 5, but also contained notes for the dates of service of October 22, 2016 (at which time it was noted that Petitioner had improved noting less lower back and significantly less left lower extremity pain) as well as the Discharge Summary dated December 7, 2016 (which noted that Petitioner was discharged with anticipated continued improvement). (RX5; PX5).

The e-mail from Barbi Henry was entered into evidence at the time of arbitration as Respondent's Exhibit 6. Ms. Henry noted in the July 28, 2016 communication that she had received FMLA and short-term disability paperwork for Petitioner as of yesterday (*i.e.*, July 27, 2016). It was noted that Ms. Henry did not have any worker's compensation paperwork at that time, but that his short-term disability paperwork stated that he injured himself at work on June 26th. Ms. Henry further noted that the physician statement indicated that Petitioner's injury was not work-related and that he was released to return to work on July 25, 2016 to full-time duty. (RX6).

The e-mail from Bob Tiepelman and the security footage was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The Arbitrator notes that no obvious injury was seen on the video, nor did Petitioner appear to have any type of altered gait. (RX7).

Various letters and e-mails to Petitioner's attorney were entered into evidence at the time of arbitration as Respondent's Exhibit 8.

The January 25, 2017 IME report of Dr. Kitchens was entered into evidence at the time of arbitration as Respondent's Exhibit 9. The report reflects that Petitioner was seen on January 25, 2017 for an IME, at which time he documented on the Accident Information Sheet "At work on Sunday and felt a pain in my back, was off Mon & Tues and rested then Tuesday afternoon was taking shorts off to get in shower and felt pain (another sharp one) then after shower couldn't bend over and barely could walk." It

was noted that Petitioner reported that he sought medical treatment around July 1, 2016, that he reported that he was experiencing pain in his lower back and into his left thigh and somewhat into his left lower leg to his shin and calf, that he reported that the pain was initially severe and that he then had some conservative measures, including therapy and injections with Dr. Coleman. (RX9).

The IME report noted that Petitioner presented with a diagnosis of a disc herniation to the left side at L4-L5, which was a far lateral/neural foraminal disc herniation and that he had symptoms of a left L4 radiculopathy noted by decreased sensation in his left thigh, weakness in the left quadriceps and decreased left patellar reflex. It was noted that with regard to the dates of his pain, Petitioner's history was inconsistent. It was noted that Dr. Kitchens was unable to given an opinion as to the timing of the disc herniation as it related to Petitioner's work activity and that he found no medical record evidence that would support that Petitioner's lumbar disc herniation occurred at work on June 26, 2016. It was noted that Dr. Kitchens opined that Petitioner's tobacco abuse played a significant role in the development of his lumbar degenerative disc disease and that Petitioner's tobacco abuse played a role in the current condition of his lumbar degenerative disc disease and the disc herniation at L4-L5. It was noted that Dr. Kitchens opined that Petitioner's disc herniated spontaneously without any traumatic event and that the factors responsible for the herniation were of a degenerative nature and were affected by his chronic tobacco abuse. It was further noted that Dr. Kitchens opined that the medical care that Petitioner received was medically necessary and reasonable; that additional medical care was necessary for his treatment of the disc herniation but could not be traced to the alleged June 26, 2016 work injury; that Petitioner could work with restrictions of limited bending, lifting and twisting and no lifting over 20 pounds; that Petitioner had reached maximum medical improvement with regard to the alleged June 26, 2016 work injury; and that the work restrictions were not related to the alleged June 26, 2016 work incident but were related to the treatment of his lumbar disc herniation at L4-L5. (RX9).

The *Curriculum Vitae* of Dr. Kitchens was entered into evidence at the time of arbitration as Respondent's Exhibit 10.

The Disability Payout was entered into evidence at the time of arbitration as Respondent's Exhibit 11. The Child Support Orders were entered into evidence at the time of arbitration as Respondent's Exhibit 12.

The Termination Letter was entered into evidence at the time of arbitration as Respondent's Exhibit 13. The letter was dated October 27, 2016 and indicated that Petitioner had exhausted all 12 weeks of leave available to him under the Family and Medical Leave Act and the additional 5 weeks of personal leave. The letter noted that Respondent was unable to hold his position open indefinitely and that his employment would be terminated effective October 27, 2016. (RX13).

The letters and e-mails regarding stipulation on diagnostic studies were entered into evidence at the time of arbitration as Respondent's Exhibit 15. The documents reflect that the parties stipulated that Dr. Kitchens had diagnostic studies available to him at the time of the IME on January 25, 2017. (RX15).

CONCLUSIONS OF LAW

With respect to disputed issue (C), the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury on June 26, 2016 that arose out of and in the course of his employment with Respondent.

In Illinois, it is well-settled that a party seeking an award under the Workers' Compensation Act must prove by direct and positive evidence, or by evidence from which the inference can be fairly and

reasonably drawn, that the accidental injury arose out of and in the course of his employment. *Corn Products Refining Co. v. Industrial Commission*, 6 Ill. 2d 439, 442-443 (1955). The burden is upon the applicant to establish by a preponderance of competent evidence all of the essential elements of his right to compensation. *Id.* at 443.

The Arbitrator finds that Petitioner's testimony at arbitration that on June 26, 2016 he injured his back while lifting a sleeve is undermined by the medical records in this matter and that the contemporaneous histories in the medical records, where available, contradict Petitioner's testimony. In so finding, the Arbitrator specifically relies upon the histories recorded at not only Barnes-Jewish St. Peters Hospital on July 1, 2016 (where it was recorded Petitioner "states the pain first began when he was leaning forward to getting to the shower" and that "[h]e denies any recent trauma or other difficulty") and Piper Spinal Care on July 5, 2016 (where it was recorded Petitioner "[g]ives a history of Tuesday getting out of the shower, bent over and felt a sharp pain…"), but also Excel Sports & Physical Therapy on July 19, 2016 (where it was recorded Petitioner "denies any prior history of lower back problems" and "[h]e was simply removing a pair of shorts when the onset of lower back pain occurred"). (PX2; PX3; RX3; PX5; RX5). Furthermore, the Arbitrator finds to be particularly compelling the fact that Petitioner further checked "[n]o" when asked "[i]s this injury work related?"at Excel Sports & Physical Therapy (PX5; RX5).

The Arbitrator notes that this is not a claim where there is one inconsistent history, but rather all of the contemporaneous histories that document a history present a consistent history of an injury at home without any mention of an injury at work. As a result thereof, the Arbitrator finds that Petitioner failed to prove that he sustained an accident on June 26, 2016 that arose out of and in the course of his employment with Respondent.

In light of the Arbitrator's findings with disputed issue (C), the Arbitrator makes no findings with respect to disputed issues (F), (J), (K) and (L), as those issues are rendered moot. The claim is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lourdes Mireles,
Petitioner,
vs.

NO: 14WC 38185

American Airlines,
Respondent.

18IWCC0363

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, 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 March 30, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $29,900.00. 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 8 - 2018
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LEC/jrc
043

Deborah L. Simpson
Deborah Simpson

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MIRELES, LOURDES
Employee/Petitioner

Case# **14WC038185**

AMERICAN AIRLINES
Employer/Respondent

18IWCC0363

On 3/30/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.90% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

1109 GAROFALO SCHRIBER AND STORM
DANIEL GRANT
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lourdis Mireles
Employee/Petitioner
v.
American Airlines
Employer/Respondent

Case # 14 WC 038185

18IWCC0363

An *Application for Adjustment 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 **2/9/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0363

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,390.98**; the average weekly wage was **$661.37**.

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

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

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

Respondent shall be given a credit of **$45,663.80** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$45,633.80**.

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

ORDER

Petitioner's claim for prospective medical care is denied.

Respondent shall pay Petitioner **temporary total disability benefits** of **$440.91/week** for **102-5/7** weeks, commencing 1/24/14 through 1/12/16, as provided in **Section 8(b) of the Act.**

Respondent shall pay Petitioner **permanent partial disability benefits of $396.82/week for 75 weeks** because the injuries sustained caused the **15% loss of use of a person as a whole**, as a whole pursuant to **§8(d)2 of the Act.**

Respondent shall pay Petitioner all compensation benefits that have accrued from 11/14/2013 to 2/9/2017 in a lump sum 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

March 30, 2017
Date

MAR 30 2017

FINDINGS OF FACT

Petitioner testified via a Spanish/English interpreter. The medical records, including the §12 examiner's reports, reveal no mention of communication deficits or the use of an interpreter. The Arbitrator noted that Petitioner answered "yes" to a question before it was interpreted and responded "right shoulder" when asked about further treatment for her shoulder on cross-examination.

Petitioner was employed by Respondent as a fleet service clerk. She loads baggage into the cargo areas of airplanes. She began working for Respondent in 1989. She would routinely lift luggage weighing between 8 to 100 pounds. The medical records document that her job has a 70 pound lifting requirement. Petitioner is right handed.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on November 14, 2013. Petitioner testified that she was carrying a bag and she felt a strong pain from her neck to her right shoulder. She was unable to work. She did not recall the weight of the bag. The medical records do not contain a history of a specific incident that caused Petitioner's pain. The records contain a history of an onset of neck and shoulder pain at work, Petitioner was loading a plane with a more than usual amount of luggage (a flight to Boston?) and noticed the onset of pain.

Following the accident in question, Petitioner was seen in the emergency room at Baylor Medical Center on November 16, 2013, reporting neck and shoulder pain after lifting at work. She was diagnosed with a cervical sprain and was given pain medication. These records were not submitted into evidence.

Subsequently, Petitioner had treatment at Nova Medical Centers with Dr. Laura Rizzo and others. She was sent to Nova by Respondent. She was diagnosed with a bilateral neck sprain and right shoulder injury. MRIs of the cervical spine and right shoulder were ordered.

On December 5, 2013, Petitioner underwent an MRI of the right shoulder. The MRI revealed a partial thickness tear of the supraspinatus and the infraspinatus tendons. That same day, she underwent an MRI of the cervical spine. It revealed disc degeneration, at C5-6 and C6-7. There was also mild central stenosis on the left at C5-6 and foraminal stenosis at C6-7. There were no disc herniations identified.

With respect to her shoulder, Petitioner sought treatment with Dr. Richard Levy commencing on December 31, 2013. With respect to her neck, she treated at Nova with Dr. Rizzo through January 17, 2014. On that date, Dr. Rizzo noted that her cervical pain had resolved, and that she was seeking additional treatment for her shoulder.

Petitioner elected to undergo surgery by Dr. Levy on March 5, 2014. The procedure consisted of an arthroscopic right shoulder surgery with debridement of the glenohumeral joint, synovectomy, subacromial decompression, and rotator cuff repair. Following shoulder surgery, she participated in an extensive amount of physical therapy, but ultimately required a manipulation under anesthesia, which was performed on November 12, 2014.

Following the second shoulder procedure, Petitioner participated in physical therapy, and work conditioning.

In May of 2015, Petitioner again began treating for her cervical condition. She ultimately proceeded with trigger point injections to the right thoracic trapezius muscles, right rhomboids and right cervical and trapezius muscles on June 3, 2015. She received diagnostic median nerve branch blocks on July 31, 2015 on the right at C4, C5 and C6.

On August 31, 2015, Petitioner underwent independent medical examinations with Dr. Brian Cole for her shoulder, and Dr. Edward Goldberg for her neck. Dr. Cole, thought that Petitioner had a resolved right shoulder condition, and that she was at maximum medical improvement status post-rotator cuff repair and post-operative capsular release for post-surgical stiffness. In terms of her ability to return to work, he opined that she was able to return to work full duty, and required no additional medical care, as it relates to her right shoulder.

Dr. Goldberg, opined that Petitioner had suffered from an aggravation of her degenerative disc disease condition as a result of the work accident. He recommended work conditioning for the cervical spine, and noted that she did not have any radicular pain. In terms of her complaints of numbness and tingling in her hand, he believed that was related to carpal tunnel syndrome. He saw no indication for any additional cervical injections, or surgery. He indicated that Petitioner would be at MMI following completion of two weeks of work conditioning.

Following the examinations, Petitioner sought treatment with Dr. Kevin James at Advanced Spine & Orthopedics. On October 12, 2015, she was examined by Physician's Assistant Reif. Petitioner reported extreme pain in her neck and progressive weakness over the last year. She rated her pain at 8/10. Physician's Assistant Reif recommended a new MRI, noting that the patient had a profound loss of strength in her right, dominant arm.

On October 21, 2015, Petitioner underwent an EMG. The EMG was negative for any signs of cervical radiculopathy on either side. However, the EMG was consistent with moderate carpal tunnel syndrome, which is consistent with the opinion of Dr. Goldberg.

On November 4, 2015, Petitioner underwent a repeat MRI of the cervical spine. It revealed a four-millimeter posterior disc protrusion at C4-5 and C5-6 that moderately effaced the thecal sac, as well as a two-millimeter central disc protrusion at C3-4 and C4-5 with mild degenerative spondylosis at C5-6. Both Dr. James and Dr. Singh testified that this study was unchanged from the December, 2013 MRI.

Petitioner was examined by Dr. James on November 20, 2015. This is the first and only time that she was examined by Dr. James. Dr. James reviewed her MRI, and opined that she was suffering from a cervical herniated nucleus pulposus with radiculopathy. He recommended that Petitioner proceed with work conditioning, or consider injections or surgery.

On January 11, 2016, Petitioner underwent an independent medical examination with Dr. Kern Singh. Dr. Singh noted numerous positive Waddell findings, and also noted a normal physical examination. He reviewed Petitioner's MRI from 2015 and opined that it was unchanged from 2013 and that it revealed loss of disc height from C4-C6 with bilateral disc osteophyte complex resulting in mild foraminal narrowing. Dr. Singh opined that Petitioner had suffered a cervical muscular strain as

a result of the accident and that she had pre-existing disc degeneration at C4-5 and C5-6. He further opined that Petitioner was able to return to work full duty, and required no additional medical care. In terms of her symptoms, he noted that they did not correlate with cervical radiculopathy related to the pathology on the MRI's based upon the examination, which was normal, as well as her EMG, which revealed no evidence of radiculopathy.

Following the independent medical examination with Dr. Singh in 2016, Petitioner has not sought additional medical care. Petitioner testified that she did want to participate in PT that had been recommended by Dr. James. Petitioner testified that she has sharp pain in her neck that she rates at 8/10. It is constant at this level. She has pain all the time. Nothing makes it worse. Petitioner has not attempted to return to work. She has not worked anywhere since being taken off work. She is receiving SSDI. There was no testimony regarding whether Petitioner is taking prescription or over the counter medication at the present time. Petitioner denied prior or subsequent injuries to her neck or right shoulder. Neither Dr. James nor Dr. Rizzo have released Petitioner to full duty work.

Petitioner submitted the evidence deposition of Dr. Kevin James. He is an orthopedic spinal surgeon. He is board certified. He testified on July 19, 2016. At that time, he confirmed that he had examined Petitioner on only one occasion (November 20, 2015). His treatment and opinions were limited to Petitioner's cervical spine condition. He opined that Petitioner had suffered a disc herniation, and was also suffering from radiculopathy. He recommended that Petitioner proceed with physical therapy, and if that was not successful, then Petitioner would be a candidate for injections and/or surgery. He causally related Petitioner's condition of ill-being to the accident in question. In terms of her ability to return to work, he indicated that at the time that he examined Petitioner, that he was of the opinion that she was not able to return to work full duty. Dr. James did not review records regarding treatment that Petitioner had prior to October 12, 2015.

On cross-examination, Dr. James indicated that notwithstanding the fact that had diagnosed her with radiculopathy, he had not reviewed the EMG report, which indicated that Petitioner was not suffering radiculopathy. In terms of Petitioner's ability to return work, he testified that he was unable to provide a current opinion in that respect, as he had only examined Petitioner on one occasion. In terms of her need for treatment, he was again unable to provide any type of an opinion as to whether Petitioner still required treatment, as he had not examined her in seven months as of the time of his testimony. When questioned on why he would recommend surgery, he indicated that he would base it primarily on Petitioner's subjective complaints of pain rather than on any objective testing. In terms of how he considered positive Waddell findings, he indicated that five positive Waddell findings would be a significant finding

Dr. Kern Singh testified at the request of Respondent via evidence deposition. Dr. Singh is an orthopedic spinal surgeon. He is board certified and an impressive CV. He testified that at the time of his examination of Petitioner in January of 2016, he was unable to correlate her allegation of radiating pain to her disc protrusions. He opined that her symptoms were consistent with a disc problem at the C7-8 level. However, Dr. Singh further noted that neither of the MRI studies revealed any type of a disc anomaly at that level. Dr. Singh further testified that, based upon the EMG study, which he opined are generally overly sensitive, the finding of no radiculopathy on the EMG was clinically significant in that it indicates that Petitioner was not suffering from radiating pain. Based upon the results of his physical examination, which he found to be normal (strength, sensation and reflexes, the results of the EMG, which were normal, and the MRI studies, which revealed age

appropriate degenerative changes, Dr. Singh opined that Petitioner's condition of ill-being was not causally related to the accident in question, and that she required no additional treatment. He did opine that Petitioner did suffer a soft tissue muscle strain as a result of the accident. He further opined that Petitioner was able to return to work full duty without restriction.

Respondent introduced surveillance footage into evidence as Respondent's Exhibit 5. The surveillance shows Petitioner moving about in an unrestricted fashion, driving, and pulling weeds in her yard over several hours on March 12, 2016. Petitioner demonstrated no outward signs of having any limitations, or any pain in her neck. She does not favor her right arm. She reaches in an unrestricted fashion. She is able to bend over and reach out and pick up weeds. She throws the weeds, underhanded, using her right arm. She can operate a complicated weeding tool, which involves using both of her upper extremities. She does not appear to exhibit 8/10 pain related to her neck or right arm.

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of her claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between her employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989) Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

The Parties agreed that if the Arbitrator found Petitioner to be at MMI and declined to make an award for prospective medical treatment, an award for PPD would be appropriate.

F. CAUSAL CONNECTION

In support of the Arbitrator's decision relating to whether Petitioner's present condition of ill being is causally related to the work injury, the Arbitrator finds:

Petitioner's current condition of ill-being regarding her right shoulder (status post lifting injury with surgical repair and eventual full duty release) is causally related to the injury. This finding is based upon the testimony of Petitioner, the medical records and the report of Dr. Cole.

Petitioner's current condition of ill-being regarding her cervical spine (age appropriate degenerative findings as shown on the MRI's with a benign physical exam as documented by Dr. Singh) is not causally related to the injury. This finding is based upon the medical records and the report and testimony of Dr. Singh. Dr. Singh's opinions are persuasive and are accorded much weight in making this finding. The Arbitrator does believe that Petitioner suffered a soft tissue

cervical muscle strain as a result of the accident, which had resolved as of the date of the §12 exam by Dr. Singh.

Dr. James opinions are not persuasive. First, he did not review records regarding treatment given to Petitioner prior to October of 2015 (with the exception of the December, 2013 MRI). He could only confirm Petitioner's findings as of November 20, 2015. He would base a surgical recommendation (primarily?) on a patient's subjective complaints of pain. The Arbitrator believes that radiographic and diagnostic studies, the results of the clinical examination and the patient's complaints of pain and disability should be considered in making the patient an offer of surgery. Finally, Dr. James did concur that 5 out of 5 Waddell's would be a significant finding. The results of Dr. Singh's examination are found to be correct.

K. TEMPORARY TOTAL DISABILITY BENEFITS

In support of the Arbitrator's, Decision as to whether Respondent is liable for the temporary total disability benefits claimed by Petitioner, the Arbitrator finds the following:

Based upon the Arbitrator's finding above regarding causal connection, Petitioner is not entitled to TTD benefits after January 11, 2016, the date of her examination by Dr. Singh. Petitioner is at MMI as of that date and is not entitled to further TTD benefits. Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission, 236 Ill.2d 132 (2010)

L. NATURE AND EXTENT

In support of the Arbitrator's, Decision regarding the Nature and Extent of Petitioner's injuries, the Arbitrator finds the following:

Pursuant to Section 8.1b of the Act, for accidental injuries that occurred on or after September 1, 2011, which include the date of accident in this case of July 16, 2012, when determining disability the Arbitrator must consider the following factors:

(i) The reported level of impairment per AMA guidelines;

(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.

According to this same section of the Act, no single enumerated factor shall be the sole determinate of disability. In determining a level of disability, the relevance and weight of any factor used in addition to the level of impairment as reported pursuant to the AMA guidelines, must be outlined by the Arbitrator. 820 ILCS 305/8.1b.

With respect to each of the factors outlined above, the Arbitrator notes the following:

(i) AMA impairment rating:

The Arbitrator notes that neither Party offered an impairment rating into evidence. As such, the Arbitrator gives no weight to this factor in determining PPD.

(ii) Occupation of Employee:

At the time of the accident, Petitioner was employed by the respondent as a fleet service clerk. Petitioner has not attempted to return to work full duty for Respondent. However, Dr. Cole opined that she was able to return to work full duty with respect to her shoulder. Further, Petitioner admitted that she was released to return to work full duty for her shoulder by Dr. Levy.

In terms of her neck, Dr. Singh has opined that she is able to return to work full duty. As noted above, the Arbitrator findsthe opinions of Dr. Singh to be persuasive in this case. Accordingly, the Arbitrator concludes that the injury has not had any adverse effect on Petitioner's ability to return to work full duty for Respondent. This factor is given some weight in determining PPD.

(iii) Age of The Employee at The Time of The Injury:

At the time of the injury, Petitioner was 55 years old. She is currently 58 years old. This factor is given some weight in determining PPD, as the after effects of the surgical repair of petitioner's dominant shoulder may affect her more than if she was younger.

(iv) The Employee's Future Earning Capacity:

Petitioner has not attempted to return to work in any capacity. However, Dr. Cole and Dr. Singh have opined that she is able to return to work full duty without restrictions for both injuries.

Based upon the evidence adduced, the Arbitrator finds that the injuries sustained by Petitioner on November 14, 2013 have not had any adverse effect on her earning capacity. This factor is given no weight in determining PPD.

(v) Evidence of Disability Corroborated by Treating Medical Records:

At trial, Petitioner complained of pain at 8/10 along with weakness, fatigue and radiating pain. There are no recent treatment records to use to determine whether her complaints are corroborated by her treatment records. In this case, the Arbitrator assigns more weight to this factor.

After carefully analyzing the five factors required by Section 8.1(b) of the Act, the Arbitrator finds that, as a result of the work injuries suffered, Petitioner sustained a 14% loss of use of the person as a whole for her shoulder injury, and 1% loss of use of the person as a whole for her cervical injury. The total PPD awarded is 15% loss of use of a person as a whole, pursuant to §8(d)2 of the Act.

O. PROSPECTIVE MEDICAL CARE

In support of the Arbitrator's, Decision regarding whether Petitioner is entitled to prospective medical care, the Arbitrator finds the following:

Based upon the Arbitrator's finding regarding causal connection, above, Petitioner's claim for prospective medical care is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LETISHA BARBER,

Petitioner,

vs. NO: 14 WC 03862

HARRAH'S CASINO,

Respondent.

18IWCC0364

DECISION AND OPINION ON REVIEW

Petitioner timely filed a Petition for Review of the Decision of the Arbitrator finding Petitioner failed to prove she sustained an accidental injury arising out of or in the course of her employment. Notice having been given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary disability, and permanent disability, and being advised of the facts and law, reverses the Decision of the Arbitrator. The Commission finds Petitioner sustained an accidental injury arising out of and in the course of her employment on June 16, 2012 and her condition of ill-being is causally related to that work injury.

Initially, we note the Request for Hearing reflects a June 6, 2012 date of accident. As the Application for Adjustment of Claim, Petitioner's testimony, and the medical records all memorialize a June 16, 2012 accident date, the Commission agrees with the Arbitrator's assessment that the June 6, 2012 date reflected on the Request for Hearing is a typographical error, and we have analyzed the case with the understanding Petitioner's alleged accident occurred on June 16, 2012 accident.

FINDINGS OF FACT:

Petitioner has been a card dealer at Harrah's Casino since 2006. T. 16, 17. She works four or five days per week and deals an average of 6,000 to 10,000 hands per shift, always dealing

with her right arm. T. 18, 21. Petitioner explained she knows her speed because Respondent monitors and times the dealers' game pace. T. 19. Petitioner is one of Respondent's fastest dealers. T. 19. She testified there is one gaming table where the dealer is seated, and the rest require the dealer to stand; Petitioner mainly deals from a standing position as the sit-down game is usually reserved for people who are pregnant or have some limitation. T. 17. The following exchange took place when Petitioner was asked to describe the mechanics of dealing at the various tables:

A. If I'm at the sit down game, the table sits a little higher, and the chair is not equipped for that table, so you're putting the cards out, and I guess we're at this level (witness indicating).
Each table is at a different height. None of them are at a consistent height. Some are lower, some are higher, some of them have a slight lean. At that time we were on the boat out in the water, so sometimes you're sitting at an angle, depending on the river level and everything.

Q. And as you were describing - - or showing us there, it appeared that you were dealing from around your chest level; is that a fair description?

A. Right, correct, correct. And I have to kind of over-extend myself because we've got a rack of money, and the money is in front of me, and I have to kind of over-extend to get the cards out to each position on the table.

Q. So your elbow doesn't hit the money?

A. Correct. T. 22-23.

Petitioner alleges she sustained an accidental injury on June 16, 2012. She described the incident: "I was dealing at my table, and as I was placing the cards out, when I got to the third spot, which is to my far right, I felt my arm, it felt like - - and I heard it, felt like a pop from the inside of me." T. 19. She experienced an immediate onset of pain radiating through the arm and shoulder. T. 24. Petitioner stated her supervisor Jeff was present, heard the pop and asked, "Was that your arm?" She responded in the affirmative and advised him it felt as though her shoulder dislocated. T. 20. There was no objection to this testimony. Petitioner testified she had no right shoulder problems or pain before June 16, 2012. T. 21. She reported the incident to her shift supervisor, Joellen Wilcox, and completed the remaining hour of her shift. T. 24.

Petitioner did not seek treatment right way, explaining she thought the pain would resolve with ice, heat, and over-the-counter medications. When her symptoms persisted, she was sent to the occupational clinic at Baptist. T. 25.

On June 26, 2012, Petitioner was evaluated at Baptistworx Occupational Health. Petitioner testified the doctor administered a cortisone injection, prescribed medication, and ordered physical therapy. T. 25. There is no office note for this evaluation however the records include a prescription documenting right shoulder pain with dealing cards at Harrah's, as well as a July 6, 2012 order for physical therapy to treat a right shoulder strain. PX3.

Physical therapy began at Baptist Rehab Center on July 10, 2012. The initial evaluation reflects a history of injury of "she was dealing blackjack and when she got to the far right she had pain in her right shoulder that felt like it almost came out of place." PX3. Physical therapy continued through early August. Petitioner testified therapy exacerbated her symptoms. T. 26.

On August 7, 2012, Dr. W. Chris Kostman performed a Section 12 examination and record review at Respondent's request[1]. Dr. Kostman documented Petitioner described the incident and demonstrated the motion she was using to deal the card: "she reached to the position to her right, felt a pop involving her right shoulder dealing the card at approximately her waist level or just above"; Petitioner advised she had no prior difficulty with her right shoulder but since the June 16, 2012 injury had persistent right shoulder symptoms. Petitioner reported pain with reaching and lifting activities as well as catching, popping and a giving way sensation involving the right shoulder. On examination, the doctor noted decreased forward flexion and tenderness involving the right shoulder with impingement sign, Hawkins test, O'Brien's test, and cross-arm adduction test. Dr. Kostman diagnosed right shoulder pain with exam findings consistent with right trapezius and rotator cuff tendinitis. The doctor indicated the recommended treatment would be a subacromial corticosteroid injection but opined there was no causal relationship between the work injury and the condition. Dr. Kostman further opined Petitioner had reached maximum medical improvement and required no work restrictions. RX1, DepX2.

Petitioner testified, following the Section 12 examination, she received a letter from Respondent advising her of Dr. Kostman's findings, and her workers' compensation benefits were subsequently terminated. T. 27, 52. At that point, Petitioner sought care from Dr. Bill Conyer and applied for short-term disability. T. 28, 55.

The consultation with Dr. Conyer occurred on August 29, 2012. Petitioner provided a history of a sudden onset of severe pain in the right shoulder when she reached laterally while dealing blackjack. Dr. Conyer noted Petitioner was initially seen under the auspices of workers' compensation at Baptist Work Clinic, however "apparently it has been determined by Workers' Compensation that her problem is not due to a work-related injury" and her employer directed she go on FMLA while she pursues further evaluation. After an examination, Dr. Conyer diagnosed right shoulder pain, etiology not determined, rule out rotator cuff tear and tendonitis. Dr. Conyer ordered a right shoulder MRI and referred Petitioner for an orthopedic evaluation with Dr. Brian Kern; Dr. Conyer additionally completed the necessary FMLA paperwork. PX4.

The recommended MRI was completed on September 4, 2012. The radiologist's impression was thickened rotator cuff tendon indicating tendinopathy, increased signal along the articulating surface of the tendon posteriorly possibly representing a partial tear, and mild acromioclavicular arthrosis with reactive edema in the distal clavicle and acromion process; no full thickness rotator cuff tendon tear was identified and the labrum was unremarkable. PX3.

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1 Dr. Kostman's reports were identified during the doctor's deposition, and are attached as exhibits thereto, however the Commission observes the reports were never formally offered into evidence. Given that both parties refer to the reports in their arguments, it is clear the parties believe those reports were received into evidence. Moreover, neither party has raised an objection to our consideration of same. Therefore, the Commission corrects this oversight and *sua sponte* admits the reports into evidence.

On September 17, 2012, Petitioner presented to The Orthopaedic Institute of Western Kentucky where she was seen by Hollis Clark, Dr. Kern's Physician's Assistant. PA Clark noted Petitioner complained of right shoulder pain dating back to June 16, 2012 when dealing blackjack; that night, she was dealing, "externally rotated and reached up a bit for dealing cards and felt a pop in her shoulder and has had pain in her shoulder since." Examination findings included severe tenderness to palpation over the acromioclavicular joint, mild tenderness over the anterolateral corner of her acromion, decreased abduction strength, and both Hawkins and Neer's tests were positive for impingement; on review of the MRI, PA Clark identified an articular-sided anterior partial thickness supraspinatus tear with an extensive amount of tendinopathy versus tear extending posteriorly, marked acromioclavicular joint osteoarthritis, and obvious signs of impingement. Treatment options were discussed and as Petitioner desired a definitive repair, she was to be scheduled for arthroscopic rotator cuff repair, subacromial decompression, and distal clavicle excision. PX2.

On October 16, 2012, Petitioner met with Dr. Kern for a preoperative consultation, and on October 31, 2012, Dr. Kern performed right shoulder arthroscopically assisted rotator cuff repair, subacromial decompression, and distal clavicle resection. The post-operative diagnosis was rotator cuff tear, impingement, and acromioclavicular joint arthritis. PX2.

Post-operatively, Petitioner was in a sling for six weeks then began physical therapy. T. 30. At the January 23, 2013 follow-up with Dr. Kern, Petitioner reported some ongoing stiffness but her pain was decreasing, and she was "doing extremely well" and very pleased. Dr. Kern recommended continued physical therapy but noting Petitioner worked at the casino and did not do any type of heavy lifting, the doctor released her to return to work without restrictions. PX2. Petitioner testified that although Dr. Kern had not imposed restrictions, Respondent voluntarily reassigned her to a less stressful job to ease her back to her regular duties. T. 42-43.

On March 6, 2013, Petitioner was re-evaluated by Dr. Kern, and she again stated she was "doing very well." The doctor noted she had completed physical therapy and returned to work without restrictions. Dr. Kern discharged Petitioner from care with follow-up as needed. PX2.

On August 13, 2013, Dr. Kostman authored an addendum after reviewing additional medical records. Therein, Dr. Kostman found Petitioner's diagnosis prior to surgery was right shoulder rotator cuff tendinitis and maintained his opinion there was no causal relationship between Petitioner's description of the June 16, 2012 incident and her diagnosis. RX1, DepX3.

On February 5, 2014, Petitioner filed an Application for Adjustment of Claim alleging a June 16, 2012 accidental injury. ArbX2.

On May 2, 2014, Dr. Kostman authored a second addendum. Dr. Kostman reiterated Petitioner's description of the work injury was she was seated at a table dealing cards from a shoe, and as she was dealing across the table, she reached a position to her right, felt a pop involving her right shoulder dealing a card at her waist level with resultant shoulder pain. The doctor opined Petitioner's diagnoses of acromioclavicular joint arthritis, rotator cuff tear, and impingement were related to anatomic configuration and degenerative findings unrelated to card dealing activities. RX1, DepX4.

On March 10, 2016, Dr. Rickey Lents performed a record review at Petitioner's request. Dr. Lents' report was not offered into evidence, however, the doctor did detail his findings and conclusions during his deposition.

Petitioner remains a card dealer for Respondent. T. 31. She stated she still feels a nagging ache in her shoulder while dealing cards. T. 32. She also described some weakness in the shoulder and has range of motion deficits. T. 32-33. She uses her left arm to compensate for the right shoulder problems. T. 35. She has not seen Dr. Kern since March 2013. T. 44.

On cross-examination, Petitioner was asked if she discussed her problem with Respondent's security officer to make a report; Petitioner testified Jeremy Delaney, who is a security officer, may have been present. T. 37. Respondent's Counsel then stated,

> He issued a report and stated he talked to you about your injury, and he issued a report on June 17 of 2012. And in an incident report he states - - I'm going to quote something here and ask you about it. He states, quote, Miss Barber was dealing Black Jack on first floor when she felt her right shoulder pop. Miss Barber informed me that there is still some discomfort in her shoulder, but she continued dealing the rest of her shift on 6-16-12 and returned to work the evening of 6-16-12, unquote. T. 37-38.

Petitioner testified she did not remember speaking to Delaney in particular, but if he was in the office with Joellen, she probably did tell him she was having discomfort. T. 38.

Petitioner was asked if she recalled telling Dr. Kostman she was dealing at waist level; she responded, "I don't know if I said waist level, but I do recall repeating to him that I was dealing the cards." T. 45. She later explained she demonstrated how she was dealing the cards:

> I showed him the motions. When I - - from the waist level, today is the first time I've ever heard of dealing from the waist level. That is a new term to me. I mean, all I know is I step up to the table, clear my hands, and I deal, because I never thought about it being from the waist level, chest level or anything, because if I am too far down, it would mean my hands were under the table. T. 58.

She reiterated the tables are very high, although they do vary. T. 58.

The evidence deposition of Dr. Kostman was taken on October 15, 2014 and admitted as Respondent's Exhibit 1. Dr. Kostman is a board certified orthopedic surgeon. RX1, p. 5. Dr. Kostman testified consistent with his reports and maintained his conclusion there was no causal connection between Petitioner's accident and her condition. Dr. Kostman testified, following his August 7, 2012 examination and record review, his impression was Petitioner's exam findings were consistent with right trapezius and rotator cuff tendinitis, and there was no causal connection between the June 16, 2012 incident and her diagnosis. RX1, p. 7. Dr. Kostman testified the receipt of additional medical records was the impetus for authoring the August 13, 2013 addendum; the doctor stated his review of those records did not change his opinions as

documented in the 2012 report. RX1, p. 8-9. Dr. Kostman testified the same is true regarding his May 2, 2014 addendum. RX1, p. 9. The doctor agreed the diagnoses documented therein were AC joint arthritis, rotator cuff tear, and impingement, and those conditions pre-existed the June 16, 2012 injury. RX1, p. 10. Dr. Kostman opined Petitioner's work injury did not cause or contribute to any of her diagnosed conditions, Petitioner's injury did not cause or contribute to Petitioner's need for medical care, and Petitioner's injury did not cause or contribute to any permanent partial disability. RX1, p. 10.

The evidence deposition of Dr. Lents, taken on August 11, 2016, was admitted as Petitioner's Exhibit 5. Dr. Lents is a board certified orthopedic surgeon. PX5, p. 5. Dr. Lents testified he reviewed Petitioner's physical therapy records, the operative report, the office notes from the treating surgeon, the MRI scan, x-ray reports, and the notes from the general practitioner. PX5, p. 7. From those records, the doctor gleaned Petitioner was a card dealer; his understanding of her June 2012 mechanism of injury was "she was dealing blackjack, as I recall, and made a motion whereby one more than likely was dealing a card but she raised her arm, made a lateral movement, and thrusting her hand into space, more than likely the motion that one would do tossing a card to a player." PX5, p. 7-8. Dr. Lents testified the description of Petitioner's injury was consistent throughout the records; the doctor further stated the records contained no evidence of any prior shoulder problems. PX5, p. 8. The records indicate Petitioner was diagnosed with a torn rotator cuff, rotator cuff tendinitis, and osteoarthritis of her acromioclavicular joint. PX5, p. 8. She opted for aggressive treatment and the surgeon performed arthroscopic repair of the rotator cuff, resection of the clavicle, and an acromioplasty. PX5, p. 9. Dr. Lents opined the treatment was necessary and appropriate. PX5, p. 9.

Regarding causation of Petitioner's condition, Dr. Lents testified, "Yes, I believe her employment contributed to it. I believe that the motion that she made when she described the pop in her shoulder probably - - probably contributed to her torn rotator cuff." PX5, p. 10. The doctor explained the significance of Petitioner reporting a pop in her shoulder: "It's frequently described, people who have like either acute or acute on chronic tears of the rotator cuff will feel or hear a snap or pop when the tendon gives way. It's commonly referred to." PX5, p. 10. Dr. Lents then detailed the difference between acute and acute on chronic rotator cuff injuries:

> There's, one, the acute tear that one sees in very young people doing very vigorous things. For instance, a baseball player who slides into home plate and gets - - can't pick his arm up or something like that, or a relatively young, healthy rotator cuff is torn. And there's a much more common tear whereby you have some chronic disease in a rotator cuff and then some action causes that tendon to rupture. So, it's - - they're both rotator cuff tears, but they're different in that one occurred in a normal healthy tendon and then one occurred in a tendon already with some disease in it. PX5, p. 11.

Dr. Lents testified Petitioner's MRI revealed degenerative changes in her shoulder. PX5, p. 11.

On cross-examination, Dr. Lents confirmed he did not examine Petitioner. PX5, p. 12. The doctor agreed performing a physical examination would have given him more insight into Petitioner's condition and whether her employment caused or contributed to it. PX5, p. 12.

Directed to his March 10, 2016 report, Dr. Lents agreed he therein stated, "I believe that her employment probably was a causative factor in the aggravation of her right shoulder tendinitis and impingement." PX5, p. 17. The doctor then confirmed he is still of that opinion. PX5, p. 17. The doctor's report further reflects, "it was probably not the main causative factor in that this was probably preexisting and due to degenerative changes that are very common in a woman of this age"; Dr. Lents agreed that statement confirmed his opinion Petitioner had pre-existing tendinitis and impingement. PX5, p. 18. The report continues, "However, the act of dealing cards and using the arm in the fashion that she would have to use it certainly could have been a causative factor." PX5, p. 18. Asked, "so you're not stating that the employment was a causative factor, just that it could have been a causative factor," Dr. Lents stated, "Yeah, I think it certainly could have. I mean, it's - - that - - the abduction external rotation movement that one makes to deal a card would have put the rotator cuff in use. And certainly could have caused it to have been the straw that broke the camel's back and made the tendon rupture." PX5, p. 19.

Dr. Lents testified he was aware Petitioner was a card dealer, but he had no information on her specific job duties, physical demands, length of her shift, or when the injury occurred. PX5, p. 20-23. The doctor stated he was unaware whether Petitioner was dealing cards at waist level, mid abdomen level, or shoulder level. PX5, p. 24. The doctor noted, "In general, the higher the arm is above your head the more stress you place on a rotator cuff." PX5, p. 24.

Presented with Dr. Kostman's conclusions, Dr. Lents agreed Petitioner had pre-existing AC joint arthritis. PX5, p. 27. Dr. Lents also agreed with Dr. Kostman's statement Petitioner's "diagnosis of rotator cuff tear is consistent with a degenerative condition and related to AC joint arthritis with subsequent impingement along with her acromion." PX5, p. 27. Dr. Lents further agreed with Dr. Kostman's statement, "impingement is related to both the arthritis involving the AC joint with narrowing and the configuration or shape of the acromion. These are both anatomic and degenerative findings and unrelated to her activities as described as a car [*sic*] dealer." PX5, p. 27. Finally, Dr. Lents agreed with Dr. Kostman's conclusion, "rotator cuff tendinitis is additionally consistent with degenerative findings as the AC joint and configuration of her acromion. All of the above diagnoses are related to anatomic configuration and degenerative findings. None of the above diagnoses are related to card dealing activities as described." PX5, p. 28.

Dr. Lents later reiterated the act of dealing a card, externally rotating the arm, involves the rotator cuff (PX5, p. 28) and explained the stresses the dealing motion has on the shoulder:

> But the more you bring the arm away from the body and begin to suspend your humerus in space, the humeral head has to be pulled into the glenoid, into the socket. In other words, the humerus is not affixed into the ball of the socket like a hip joint…But as the humerus is brought away, it's got to be held solid against the body to assign any strength so the muscles can work. That's what the rotator cuff does. Rotator cuff pulls up from here, into the socket, and stabilizes the humerus into the glenoid fossa so the other more powerful muscles can act on, you know, the muscles in your upper back, your deltoid and pectoralis, so it can spin that arm, rotate the arm, do whatever you heck you want to do. But that humerus has

got to be - - down here, right now, my humerus is probably a good two or three millimeters away from the glenoid fossa so I didn't touch...My hands are in my lap. But as one does this, now, right now my shoulder is I'm at 30 degrees or so, my humerus has probably engaged my glenoid, okay, that's my deltoid and that's done subconsciously and here it's certainly firing now, as my arm is at 90 degrees, because if my humerus is not and my glenoid is going to do that and if that does that, my arm will just give way. PX5, p. 29-30.

CONCLUSIONS OF LAW:

I. Accident

To recover benefits under the Act, a claimant bears the burden of proving by a preponderance of the evidence that she sustained an accidental injury arising out of and in the course of her employment. 820 ILCS 305/1(d). Both elements must be present to justify compensation. *First Cash Financial Services v. Industrial Commission*, 367 Ill. App. 3d 102, 105, 853 N.E.2d 799 (2006).

The "in the course of employment" element refers to the time, place, and circumstances surrounding the injury. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E.2d 665 (2003). "That is to say, for an injury to be compensable, it generally must occur within the time and space boundaries of the employment." *Id.* It is uncontroverted that Petitioner was at her designated gaming table in the midst of her shift when the shoulder injury occurred. Therefore, it is beyond question that Petitioner was in the course of her employment.

"The 'arising out of' component is primarily concerned with causal connection" and is satisfied when the claimant has "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, Inc.*, 207 Ill. 2d at 203. "There are three types of risks to which employees may be exposed: (1) risks that are distinctly associated with employment; (2) risks that are personal to the employee, such as idiopathic falls; and (3) neutral risks that do not have any particular employment or personal characteristics. [Citation.]" *Adcock v. Illinois Workers' Compensation Commission*, 2015 IL App (2d) 130884WC, ¶31. The testimonial and documentary evidence establish Petitioner, a card dealer, was "over-extending" her right arm to reach over the money rack and deal a card to the player on her far right, *i.e.*, performing an act she was instructed to perform by her employer, when her shoulder injury (an acute "pop" and onset of pain) occurred. Petitioner was performing the job duties she was hired to perform-dealing cards. Under these facts, the Commission finds Petitioner's injury originated in a risk connected with her employment and therefore arose out of her employment. The Commission finds Petitioner sustained an accidental injury arising out of and in the course of her employment on June 16, 2012.

II. Causation

A work-related injury need not be the sole or principal causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. *Sisbro, Inc.*, 207 Ill. 2d at 205. Thus,

even if the claimant had a preexisting degenerative condition which made her more vulnerable to injury, recovery for an accidental injury will not be denied as long as she can show her employment played a role in aggravating or accelerating the preexisting condition. *Id* at 204-5. In denying the claim, the Arbitrator found it "significant that none of the treating physicians in this case reached any conclusions regarding a causal connection of Petitioner's condition to her work duties." This finding was seemingly premised on Respondent's assertion that "in virtually all Illinois workers' compensation cases" the treating physician routinely provides a causation opinion yet Petitioner's doctors "refused," so therefore they must not have believed the condition was work-related. The Commission finds the evidence does not support that inference.

Hyperbolic claims aside, the Commission observes there is no indication a causation opinion was ever sought from either Dr. Conyer or Dr. Kern. This is likely because Petitioner was not represented at the time she was treating with those physicians. To be clear, Petitioner's Application for Adjustment of Claim was not filed until February 2014, nearly a year after she was placed at maximum medical improvement, and Dr. Kern discharged her from care. As such, there was no pending Commission claim and no one acting on Petitioner's behalf who would have known to ask either Dr. Conyer or Dr. Kern to address causation. The doctors cannot be said to have "refused" to provide a causation opinion when there is no evidence the request was made. The Commission finds inferring the treating physicians denied causation under these circumstances is improper.

There is no real question Petitioner had pre-existing degenerative disease in her shoulder, although we note there is conflicting evidence as to whether her AC joint osteoarthritis was mild or marked. There are conflicting opinions from the two experts on the aggravation question: Dr. Kostman and Dr. Lents. The Arbitrator found Dr. Lents' opinion was not persuasive, adopting Respondent's position that the doctor "never actually stated that Petitioner's employment caused or contributed to her condition. Rather, he would only state that the employment *probably* caused or *could have* caused or contributed" (Emphasis in original), and instead found Dr. Kostman "[eminently] more persuasive and credible," observing "he testified with certainty that the employment neither caused nor contributed to Petitioner's shoulder condition." The Commission views the doctors' opinions differently.

Initially, the Commission emphasizes that dating back to the 1970s, the Supreme Court of Illinois has held a finding of a causal relationship may be based on a medical expert's opinion that an accident "could have" or "might have" caused an injury. See, *County of Cook v. Industrial Commission*, 69 Ill. 2d 10, 18, 370 N.E.2d 520 (1977) (It is not necessary for a medical witness to testify positively as to the cause of medical condition. "Such witness may testify in terms of 'could have' or 'might have' despite any objection that his or her testimony is inconclusive or speculative.") Therefore, Dr. Lents' conclusion that "the abduction external rotation movement that one makes to deal a card would have put the rotator cuff in use. And certainly could have caused it to have been the straw that broke the camel's back and made the tendon rupture" (PX5, p. 19), was sufficient to support a finding of causal connection and should not have been dismissed for a perceived lack of definitiveness. Further, while we agree Dr. Kostman had the benefit of examining Petitioner, the Commission finds Dr. Kostman's opinion that Petitioner's diagnoses are solely the result of her pre-existing anatomic and degenerative condition is inconsistent with the evidence. We emphasize there is no evidence of any prior

treatment or problems. Petitioner testified her shoulder was asymptomatic, and we find this testimony credible. Moreover, what the Commission finds compelling is the "pop" Petitioner described which is consistently documented in the treating records as well as the Section 12 reports: Petitioner felt her shoulder pop while "over-extending" her arm to reach over the money rack and deal the card, in what Dr. Lents described as an "abduction external rotation movement...which puts the rotator cuff in use." PX5, p. 19. As Dr. Lents explained, the popping phenomenon is frequently used to describe the instant when the "tendon gives way." The Commission finds Dr. Lents' opinion is supported by the evidence and establishes an acute change in Petitioner's right shoulder condition. Also, while certainly not dispositive, we further note Dr. Lents' testimony regarding popping of a tendon is consistent with what we have observed in numerous claims.[2]

Given the absence of any evidence of prior shoulder problems, the consistently documented "pop" in Petitioner's shoulder while she performed an abduction external rotation motion to deal to her far right, and Dr. Lents' persuasive opinions, the Commission finds Petitioner proved by a preponderance of the evidence that her work activities were *a* factor in her right shoulder condition of ill-being.

III. Temporary Disability

On the Request for Hearing, Petitioner alleges entitlement to Temporary Total Disability benefits from August 13, 2012 through March 6, 2013. The Commission notes there was no direct testimony regarding when Petitioner began missing work, and there is no record of a medical evaluation on August 13, 2012 to correspond with the Request for Hearing. Dr. Conyer's August 29, 2012 record indicates Petitioner "is unable to work due to persistent right shoulder problems and has been advised by her employer that she will need to go on FMLA leave"; as part of his treatment plan, Dr. Conyer "placed [Petitioner] on FMLA, papers completed today." PX4. Therefore, the medical records indicate Petitioner was first authorized off work on August 29, 2012. Petitioner thereafter underwent surgery on October 31, 2012 and remained off work post-operatively until January 23, 2013, when Dr. Kern released her to full duty. PX2. As Petitioner's stipulated average weekly wage is $648.25, the Commission finds Petitioner is entitled to Temporary Total Disability benefits of $432.17 per week from August 29, 2012 through January 23, 2013.

IV. Medical

Having analyzed the medical records, and in light of the Section 12 physicians' agreement as to the appropriateness of Petitioner's care, the Commission finds Petitioner's treatment was reasonable and necessary pursuant to Section 8(a) and causally related to Petitioner's work injury. Respondent is ordered to pay the expenses associated therewith, subject to Section 8.2. Respondent shall have credit for amounts previously paid.

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2 The Commission is an administrative tribunal that hears only workers' compensation cases and deals extensively with medical issues. See *Krantz v. Industrial Commission*, 289 Ill. App. 3d 447, 450-51, 681 N.E.2d 1100 (1997) The Commission possesses inherent expertise regarding medical issues. *Long v. Industrial Commission*, 76 Ill. 2d 561, 566, 394 N.E.2d 1192 (1979).

The Commission notes Petitioner's Exhibit 7 reflects charges for an admission to Western Baptist Hospital from March 4, 2012 through March 8, 2012 for labor and child birth. This expense is clearly unrelated to Petitioner's accidental injury and is denied.

V. Permanent Disability

Petitioner's work accident occurred after September 1, 2011; therefore, Section 8.1b is applicable. Section 8.1b(b) requires permanent partial disability be determined following consideration of five factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. 820 ILCS 305/8.1b(b).

Section 8.1b(b)(i) – §8.1b(a) impairment report

Neither party submitted a §8.1b(a) impairment report. The Appellate Court has held an impairment report is not a prerequisite to an award of permanent partial disability benefits. *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶47, 56 N.E.3d 1101. As such, the Commission will assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner returned to her pre-accident job as a card dealer. This job requires repetitive use of the affected shoulder and arm which Petitioner testified she is able to do. The Commission finds Petitioner's successful return to unrestricted work is significant and weighs heavily in favor of reduced permanent disability.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 36 years old on the date of her accidental injury. Petitioner is relatively young and will therefore face any residual disability for a longer period. The Commission finds this factor weighs in favor of increased permanent disability.

Section 8.1b(b)(iv) - future earning capacity

No evidence was offered to suggest the injury had any impact on Petitioner's future earning capacity. The Commission finds this weighs in favor of reduced permanent disability.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Petitioner underwent arthroscopic surgery followed by post-operative physical therapy. Within three months of surgery, Dr. Kern released her to full duty and on March 6, 2013, the doctor discharged her from care with no permanent restrictions. At that final medical visit, Dr. Kern documented resisted range of motion 4+/5 compared to the contralateral side, and

18IWCC0364

Petitioner had no tenderness. The Commission notes Dr. Kern's records are consistent with Petitioner's description of relatively benign residual complaints, including a nagging ache while working and minor strength and range of motion deficits. T. 32-33. The Commission finds these facts evidence a positive surgical outcome and weigh heavily in favor of reduced permanent disability.

Based on the above, the Commission finds Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of the person as a whole under Section 8(d)2.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $432.17 per week for a period of 21 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 $388.95 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 7.5% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses under §§8(a) and 8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $48,100.00. 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 8 – 2018

L. Elizabeth Coppoletti

LEC/mck

O: 4/11/18

Charles J. DeVriendt

43

Joshua D. Luskin

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Corrie Shemonic,
Petitioner,

18IWCC0365

vs.

NO: 14WC 35349

Chester Mental Health Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 5, 2017, is hereby affirmed and adopted.

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

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

No bond or summons required for State of Illinois cases.

DATED: JUN 8 – 2018
d060518
LEC/jrc
043

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHEMONIC, CORRIE
Employee/Petitioner

Case# **14WC035349**

CHESTER MENTAL HEALTH CENTER
Employer/Respondent

18IWCC0365

On 12/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4075 FISHER KERKHOVER & COFFEY
JASON COFFEY
1300 1/2 SWANWICK ST POB 191
CHESTER, IL 62233

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

DEC 5 - 2017

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

CORRIE SHEMONIC
Employee/Petitioner

v.

CHESTER MENTAL HEALTH CENTER
Employer/Respondent

Case # **14** WC **35349**

Consolidated cases: _____

18IWCC0365

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

On the date of accident, **August 22, 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 **$33,376.80**, and the average weekly wage was **$641.86**.

At the time of injury, Petitioner was **34** years of age, ***married*** with **2** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$385.12 per week** for **142.5 weeks**, because the injuries sustained caused the loss of use of **28.5% of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **April 5, 2016** through **December 14, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

November 30, 2017
Date

DEC 5 - 2017

STATEMENT OF FACTS and CONCLUSIONS OF LAW

The Petitioner, Corrie Shemonic, testified she was a thirty-four year old support service worker at Chester Mental Health Center on August 22, 2014 when she was unloading five cases of milk from a freezer to a refrigerator. Upon completing this task, she went to pull a coffee filter out over a counter out of a coffee machine and felt immediate low back pain. She sought immediate medical treatment following her work injury at the emergency room at Chester Memorial Hospital, reporting the sudden onset of back pain into the right leg with bilateral leg numbness following the accident. The notes indicate the Petitioner had received an epidural injection on 8/15/14 with her pain management physician, and that surgery had previously been recommended by Dr. Heffernan. The Petitioner testified she was examined at Chester Memorial Hospital, and, based upon the examination, and Petitioner's complaints of an inability to move her legs, she was transferred to St. Louis University Hospital (SLU) for neurosurgical evaluation due to concern for cauda equine syndrome. (Px1).

At SLU, the Petitioner reported a history of a "slipped disc", and that when she was reaching for an object at work earlier her legs went weak and then numb, with an inability to move her legs, through she was able to stand and walk with assistance. An MRI showed normal discs from L1 to L4, a diffuse L4/5 bulge with mild facet arthropathy and no foraminal stenosis, and at L5/S1 a diffuse bulge with superimposed left paracentral disc

protrusion compressing the left S1 nerve root, contributing to mild central canal stenosis, and mild bilateral facet arthropathy with mild bilateral foraminal stenosis. A history notes chronic back pain and sciatica for 3 years, and that a 2012 MRI had been performed. The Petitioner underwent emergency low back surgery the next day due to a diagnosis of early cauda equina syndrome with progression. This surgery involved bilateral inferior hemilaminectomy with bilateral discectomies at L5/S1. The report noted that the L5/S1 disc on MRI appeared to not have changed much from prior films, but that she had progressive weakness and lack of sensation after feeling a popping sensation at the time of the accident. The surgeon, Dr. Alander, stated: "With those findings, we felt that this is progression of a disc herniation that would slid [sic] into cauda equina." The report also noted removal of large pieces of herniated disc. Following surgery, she was hospitalized until her 8/25/14 discharge. (Px2).

On 9/26/14, Petitioner reported to Dr. Alander that she had done well until about a week prior, when she had increased left leg pain with no inciting event, noting the symptoms were severe and similar to her initial symptoms, only now more on the left side. Following a repeat MRI which indicated an L5/S1 re-herniation impacting the left S1 nerve root, with Dr. Alander's indication of limitation of gastroc motor function, he performed a second surgery on 10/16/14 involving an L5/S1 microdiskectomy. Again, multiple disc fragments were removed. A pre-op report noted he had recommended a fusion at this level as well due to a "totally incompetent disc" at that level, with a likelihood of ongoing problems with just a discectomy. At a 1/21/15 follow up, Petitioner reported her leg pain was doing pretty well, but she had ongoing back pain, with Dr. Alander stating that "unfortunately we were unable to get a fusion done because of insurance reasons." Water therapy and ongoing light duty was recommended. (Px2 & Px3).

The Petitioner was examined by Dr. Matz at the request of the Respondent on 12/3/14. While he noted the Petitioner had a preexisting condition at L5/S1 and that she suffered a "temporary" aggravation of this, he also opined that the need for her surgeries was related to the aggravation of her lumbar spine at the time of the work accident. (Rx4)

Due to ongoing back pain, the Petitioner underwent a third lumbar surgery with Dr. Alander on 3/19/15. He performed a posterior interbody L5/S1 fusion with caging and instrumentation, with use of allograft and harvested iliac crest bone marrow. (Px3). He felt that she would do well given she had good disc status above the fusion level. The Petitioner was discharged on 3/22/15, and continued to follow-up with Dr. Alander over the next year, undergoing extensive physical therapy over that time. (Px2 & Px4).

The Petitioner underwent a functional capacity evaluation (FCE) at Chester Memorial Hospital on 6/24/15. The therapist who evaluated the Petitioner indicated that she appeared to provide her best effort and performed consistently. Petitioner reported her job with Respondent involved frequent to constant standing, lifting heavy pans, bending over to wash dishes in a deep sink, unloading carts, pushing milk crates, unloading groceries, walking long distances and occasional squatting. She was found to be capable of activity at the "heavy" work demand level, which is defined as occasional lifting/force between 50 and 100 pounds, frequently between 25 and 50 pounds, and constantly between 10 and 20 pounds. (Px4).

On 7/6/15, Dr. Alander allowed the Petitioner to return to work on a graduated basis working 4 hours per day the first week, six hours a day for the next week, and then a full work day with a twenty pound weight restriction. At the end of the month, the Petitioner would be able to resume full duty work without restrictions. On 10/6/15, Dr. Alander noted Petitioner had returned to regular duty and was taking Aleve for pain, noting she had occasional onset of severe pain at the PSIS that "almost makes her legs drop out." She had been walking over two miles per day, and x-rays showed good fusion positioning. She was to follow up in 6 months. (Px2). The Petitioner testified that Dr. Alander released her from care on or about 4/5/16. The Petitioner was released

to return to work without restrictions. Unfortunately, the Arbitrator was unable to locate this report within the evidence submitted into the record.

The Petitioner was evaluated by Dr. Katz at the request of her employer on 10/10/16. Dr. Katz authored a report containing an AMA disability rating (Rx2). Dr. Katz concluded the Petitioner had a 12% impairment of the whole person He noted the Petitioner fit into the Class 2 category of motion segment lesion or disk herniation with a range of ratings of 10%-14% impairment of the whole person pursuant to Pg. 570 of the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition. The default rating is 12% based upon Dr. Katz's physical examination showing residua of sensory deficit, lack of motor or reflex deficit, activity level (Grade 2), pain disability questionnaire (Grade 2), and physical exam (Grade 2). Based upon Dr. Katz's review of the Petitioner's medical records, he saw "no pre-existing conditions." Dr. Katz listed the Petitioner's present issues to be moderate pain, pain preventing the Petitioner from walking more than 1 mile, pain preventing the Petitioner from sitting for more than 1 hour, pain preventing the Petitioner from standing for more than 1 hour, less than six hours of sleep per night, pain preventing the Petitioner to engage in a normal sex life, and pain restricting journeys of less than one hour. Dr. Katz also believed the Petitioner was depressed, and this developed subsequent to the injury. He concluded the Petitioner was at maximum medical improvement in regard to her low back, with a prognosis of continued moderate low back pain, and that her quality of life would be improved if her depression was addressed. (Rx2).

The Petitioner testified she did return to the job she had at the time of the accident at Chester Mental Health Center and was able to perform her job duties. However, she did take a promotion into a new position at Menard Correctional Center about a month prior to the hearing as an Office Associate. She works in the mail room there, where she sorts through mail and locates the cells of inmates receiving the mail. The Petitioner testified she has not suffered a loss of income due to the work injury – it appears that she earns a higher wage at Menard, but works less overtime, and overall "it evens out."

With regard to her current condition, the Petitioner testified she has a hard time going anywhere that takes over an hour. She described difficulty with playing with her children, her sex life and performing chores and using the stairs in her home due to pain. She indicated difficulty with long walks. The Petitioner testified she does not take any medication to treat depression, but does take medication to help her sleep at night, which is impacted by her low back pain. At work, the Petitioner testified she has to make sure she gets up and moves around after a certain period of time because she starts to hurt, and the pain can go down her legs.

On cross-examination, the Petitioner agreed that she did have problems with her back prior to her work injury, and had previously had a recommendation for lumbar surgery, but she testified that the work accident caused an increase in her back pain. The Petitioner testified she still takes Hydrocodone every other day or so for her current back pain. She continues to see her primary-care physician, Dr. Molnar, for her back pain and medication refills.

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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

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

injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 12% of the whole person as determined by Dr. Katz pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (Rx2). 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 Arbitrator gives this factor some weight in the permanency determination, and notes that it tends to show a lesser degree of permanency.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a support service worker at the time of the accident and that she was able to return to that position following her release by Dr. Alander. She has since accepted a new position with the Respondent at Menard Correctional Center. It appears that this job is significantly less physical than her the support service worker position at Chester. The Arbitrator gives this factor some weight in the permanency determination, and notes that this tends to show a lesser degree of permanency.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 34 years old at the time of the accident. Neither party has submitted specific evidence with regard to the impact of the Petitioner's age on her permanent condition. In this case, however, the Arbitrator notes that the Petitioner has undergone several lumbar surgeries that are very significant at her age. She did have a significant preexisting condition. The Arbitrator finds that this factor tends to show a greater than average degree of permanency.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner not only was able to return to her regular job, but indicated that she accepted a promotion. While she testified that she works less overtime than she had at Chester, it also appears that her regular wages have increased. The Arbitrator finds this factor to be essentially neutral in the permanency determination.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the Petitioner testified to some ongoing post-surgical issues she has which impact both her vocational and personal life. She notes some ongoing back pain that can still radiate into her right leg. She also notes difficulties with dealing with children, her sex life, household chores and prolonged travel. As noted above, the final report of Dr. Alander is not included in the evidentiary record. However, his second to last report from October 2015 indicates the Petitioner reported the occasional onset of severe pain at the PSIS that

"almost makes her legs drop out." However, she had been walking over two miles per day, and x-rays showed a solid fusion with good hardware positioning.

The Petitioner clearly had a serious preexisting lumbar condition. At the same time, as a result of the undisputed accident in this case, she underwent three separate surgeries, and the last one appeared to be due to the Respondent's disagreement with a fusion procedure at the time of the second surgery. Additionally, the Respondent's examining physician, Dr. Katz, opined that the Petitioner has some level of depression subsequent to her injury. The Petitioner credibly testified to ongoing pain and difficulties due to the back injury.

Based on the above factors, the record taken as a whole and a review of prior Commission awards involving similar injuries and similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 28.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LESBIA GOMEZ,

Petitioner,

vs. NO: 13 WC 35260

ANDREA SANDERS D/B/A SUPERIOR LABORER SERVICES,

Respondent.

18IWCC0366

DECISION AND OPINION ON REVIEW

Petitioner timely a Petition for Review of the Decision of the Arbitrator. Respondent, without filing a Petition for Review, filed a Statement of Exceptions to the Decision of the Arbitrator. Notice having been given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary disability, and permanent disability, and being advised of the facts and law, makes the following findings of fact and conclusions of law.

FINDINGS OF FACT:

Petitioner is Spanish-speaking and testified through an interpreter. Petitioner began working as a housekeeper for Respondent on November 27, 2012. PX2. Asked to describe her job duties, Petitioner responded, "I have to do everything in the room. I have to lift those thick mattresses, and that's how I got hurt." T. 8. She then clarified she was lifting a heavy mattress on January 20, 2013 and injured the right side of her back. T. 8-9. Petitioner reiterated this mechanism of injury on cross-examination, stating, "...I lift up the mattress and I immediately felt the cracking in my back on the right side." T. 20. She was not undergoing any back treatment at the time of the injury. T. 10. Petitioner testified she informed her employer of the injury. T. 9.

On January 25, 2013, Petitioner presented to the emergency room at Memorial Medical Center. PX4. The face sheet reflects the visit stemmed from an employment-related accident on January 19, 2013. The physician documented Petitioner was not an English speaker and the

history was obtained from her husband who advised Petitioner had an onset of back pain after lifting a mattress 15 days prior. The history further indicates the incident occurred at home. Physical examination findings included tenderness at the lumbothoracic junction and the paraspinal muscles. The physician diagnosed a back strain and prescribed pain medication. The Commission observes a Request for Amendment of Record was filed by Petitioner indicating the report incorrectly identified the date and location of the incident; an addendum is attached to the records which reflects the injury happened at work. PX4.

On January 31, 2013, Petitioner returned to the Memorial Medical Center emergency room. The emergency room staff again noted Petitioner was Spanish-speaking only and all information was provided by her husband. Petitioner's complaint was described as right low back pain for the past two weeks; her husband reported Petitioner was a housekeeper and began having pain after lifting mattresses at work. The pain medication she received at the emergency room six days prior was not helping her pain and she had developed right leg numbness. The physician noted Petitioner was able to walk without difficulty. Examination revealed tenderness at L3-S1 as well as the right rhomboids and latissimus dorsi, right palpable spasms, negative straight leg raise bilaterally, and full range of motion. Petitioner was diagnosed with lumbar strain and back spasm and provided with additional pain medications. PX4.

Petitioner's Exhibit 2 is an undated Form 45 prepared by Andrea Sanders, Respondent's owner. This report documents a January 20, 2013 accident date. Ms. Sanders memorialized Petitioner's injury as "back pain from lifting...cleaning in hotel room." Petitioner's last day worked was listed as February 6, 2013. PX2.

On February 12, 2013, Petitioner presented to South Sixth Express Care with complaints of right-sided flank pain for the past two weeks. The history indicates Petitioner was a housekeeper at a local hotel and had been experiencing increasing back pain. Petitioner's husband expressed concern for his wife due to the nature of her job lifting mattresses, cleaning bathrooms, bending and stretching, and reported Petitioner had spoken with her manager and no light duty would be provided. On exam, Petitioner was severely tender at the right flank and upper quadrant, grimacing and crying out in pain with mild palpation, and moderately tender to the right flank back and thoracic musculature. Petitioner was transferred to Memorial Medical Center for further evaluation. PX4.

Once at the Memorial emergency room, a translator was provided so Petitioner could communicate directly. Petitioner stated she injured her back lifting a heavy mattress and her pain had gradually worsened; she also reported she continued to lift at work. She complained of right mid and lower back pain radiating down the back of her right leg with tingling. Physical examination findings included diffuse right lower thoracic and lumbar tenderness and moderate tenderness of the right flank; a CT of the abdomen/pelvis was negative. The physician diagnosed back pain and sciatica, prescribed pain medication, and authorized Petitioner off work for the next 10 days or until released by her primary physician. PX4.

Petitioner testified she began seeing Dr. Swapna Allamreddy at Central Counties Health Center. T. 11. The initial evaluation took place on February 13, 2013. Petitioner complained of back pain and stated she was evaluated at the emergency room the day before and was

wondering about physical therapy. Dr. Allamreddy diagnosed lumbago and recommended bed rest for a couple days followed by physical therapy. PX8.

On February 21, 2013, an Application for Adjustment of Claim was filed alleging a January 20, 2013 accidental injury. The case was assigned number 13 WC 5780 and Petitioner was represented by Warren E. Danz, PC.

Physical therapy commenced on March 7, 2013 at Memorial Medical Center. The initial evaluation, which notes Petitioner did not speak English and her husband acted as historian, indicates an original onset of pain in November 2012 with increasing symptoms in January 2013; the mechanism of injury was listed as working as a housekeeper. PX4. Petitioner attended three therapy sessions over the next two weeks then followed up with Dr. Allamreddy on March 20, 2013. The doctor memorialized complaints of middle back pain radiating to the right thigh; therapy was reportedly not of any benefit. Dr. Allamreddy further noted Petitioner was accompanied by her daughter and husband were acting as primary historians; Petitioner's daughter expressed concern about mother's pain and requested a referral to a specialist, indicating she did not think this was a muscle related problem but rather a disc prolapse as she had the same problem for which she was undergoing surgery. Dr. Allamreddy observed Petitioner's symptoms were very vague and opined the differential diagnosis was very broad, "could be muscle spasm or tear most likely." Dr. Allamreddy ordered MRIs of the thoracic and lumbar spine, referred Petitioner to an orthopedist, and imposed restrictions of no heavy lifting or strenuous activity and no working over five to six hours. PX8.

On April 23, 2013, Petitioner presented to SIU Healthcare and was evaluated by Jacob Monsivais, PA. The records reflect Petitioner had been referred by Dr. Allamreddy for evaluation of back pain. Petitioner's father acted as interpreter and conveyed an injury at work on January 20, 2013 while picking up a mattress followed by a significant increase in pain a month later. Petitioner described radiating symptoms to the right thigh and calf with minimal to no symptoms to the left. Examination revealed limited flexion and hyperextension, mild right sciatic notch tenderness, and mild right sitting straight leg raise; x-rays showed minimal degenerative changes, good alignment, and no instability on flexion/extension. PA Monsivais diagnosed subacute low back pain; lumbar radiculopathy; and muscle spasms, complicating low back pain. A lumbar spine MRI and aquatic therapy were ordered. PX5.

On May 1, 2013, the lumbar spine MRI was performed. The radiologist's impression was minimal degenerative changes, with no disc herniation, spinal stenosis, or foraminal stenosis at any level. PX9.

Petitioner underwent physical therapy at St. John's Hospital from May 2 through May 17 (PX9), then followed up with PA Monsivais on May 20, 2013. PA Monsivais noted Petitioner reported her pain worsened with therapy. Reading the MRI images, PA Monsivais identified minimal degenerative changes, a small disc bulge at L4-5, a possible annular tear posteriorly at L5-S1, minimal foraminal narrowing at bilateral L5, and no spinal stenosis. He recommended an EMG of the lower extremities followed by a possible lumbar epidural steroid injection. PX5.

On May 24, 2013, Petitioner's husband phoned PA Monsivais asking about work

restrictions. PA Monsivais advised Petitioner could do activities as tolerated but suggested limiting twisting, bending and lifting; a work note was created to that effect. PX5. Petitioner's husband phoned again on May 31, 2013 and stated there is no way Petitioner could work with those limitations and inquired if she could be off work until she had the steroid injections. PA Monsivais acquiesced and authored a work note authorizing Petitioner off work. PX5.

The EMG was performed by Dr. Brajesh Agrawal on June 10, 2013. The study was normal with no electrodiagnostic evidence for lumbosacral radiculopathies, plexopathies, or any other focal mononeuropathies in the lower extremities. PX5.

On June 19, 2013, Petitioner consulted with Dr. Ferdinand Salvacion of SpineWorks Pain Center. Dr. Salvacion noted due to Petitioner's very limited knowledge of English, the history was obtained with help from her husband. Dr. Salvacion memorialized Petitioner worked as a maid in a hotel and while changing bed linens she was picking up the mattress and moving it around and hurt her back. Her pain was 10/10 and started in the right low and middle back, radiating to her right buttock and hip. Petitioner reported "anything makes her pain worse and nothing makes her pain better." Upon examining Petitioner and reviewing the EMG and MRI, Dr. Salvacion recommended lumbar epidural steroid injections to address Petitioner's minimal degenerative disc disease. PX4.

On June 27, 2013, Dr. Kevin Rutz performed a Section 12 examination and record review at Respondent's request. A translator was present for the exam. Petitioner reported she had no back problems until January 20, 2013; on that date, she was doing housekeeping for the Hilton and bent down to pick a mattress half way up and felt pain in her right lower back. She took three days off and upon her return to work lifted another mattress to tuck in the sheets and had an increase in pain. Petitioner complained of pain in her mid right thoracic spine going down to the right lumbar spine and into her right posterior thigh. Dr. Rutz's examination findings included mildly dramatic gait; decreased lumbar flexion and extension with greater discomfort on extension; tenderness to palpation in the midline of lumbar spine and right-sided mid to lower thoracic paraspinal musculature, right buttock, and over the right hip greater trochanteric bursa; and positive straight leg raise for lower back pain; the doctor additionally observed Waddell's positive for overreaction and superficial tenderness. Dr. Rutz noted his review of the x-rays, CT, and MRI images revealed Petitioner's lumbar spine was normal without any signs of any significant degeneration or injury. The doctor diagnosed right lower thoracic and lumbar back pain, indicated the treatment to date had been medically reasonable, and recommended a thoracic spine MRI. Dr. Rutz opined Petitioner's lumbar spine condition was not related to a repetitive trauma injury or a single lifting event manifesting on January 20, 2013. Dr. Rutz opined Petitioner was "simply bending over to lift up the corner of a mattress. This is basically an activity of daily living," and indicated Petitioner would have had the same problem regardless of whether or not she had bent over to pick up the corner of a mattress. Dr. Rutz documented his concerns of symptom magnification, identifying overreaction, superficial tenderness, a non-physiologic distribution of symptoms, and pain with simply walking on her toes and heels, which is not physiologic. The doctor also noted "a profound lack of any pathology in her lumbar spine," and concluded Petitioner's symptoms were in a non-physiologic distribution for any pathology in the lumbar spine and her symptoms seemed somewhat magnified. RX2.

On June 28, 2013, Dr. Salvacion performed a lumbar epidural steroid injection at L4-5. PX4. Petitioner followed up with Dr. Salvacion on July 12, 2013 and reported no relief from the injection. Noting the presence of a trigger point in the right latissimus, Dr. Salvacion proceeded with a trigger point injection. PX4.

On July 31, 2013, Petitioner returned to SIU Healthcare and was evaluated by Dr. Per Freitag. The records reflect Petitioner's chief complaint was mid back pain which she related to lifting heavy mattresses on January 20, 2013. She had previously tried epidural steroid injections, trigger point injections, medications, and aqua therapy with no relief. Dr. Freitag noted the lumbar spine MRI showed no pathology and the EMG was negative for evidence of radiculopathy. Dr. Freitag diagnosed right-sided mid back pain with evidence of right paraspinals muscle spasms; he prescribed DMSO cream and ordered a chest MRI to further assess soft tissue pathology. PX5.

Petitioner followed up with Dr. Salvacion on August 1, 2013 and reported no benefit from the trigger point injection. The doctor ordered a thoracic spine MRI to rule out a thoracic disc herniation. PX4. The thoracic spine MRI was completed on August 13, 2013; at the August 16, 2013 follow up appointment, Dr. Salvacion noted the scan was normal. The doctor further noted Petitioner continued to complain of pain in the right-sided thoracic region and low back. Dr. Salvacion indicated he did not have any other recommendations and Petitioner would follow up with Dr. Freitag. PX4.

Dr. Freitag's records reflect Petitioner's husband phoned on August 26, 2013 and asked to schedule an appointment to get updated work restrictions prior to a September 9, 2013 hearing date. Dr. Freitag reviewed the diagnostics and as the results were normal, stated he was unable to authorize Petitioner off work. Petitioner was placed on the cancellation list for a sooner appointment. PX5.

On September 3, 2013, Petitioner presented to Dr. Daniel Hoffman. Dr. Hoffman opined Petitioner sustained a tear of the L5-S1 disc and bulging as a result of the January 20, 2013 work injury. Based on his clinical exam, the doctor recommended she consult with Dr. Richard Kube for his orthopedic opinion. PX11.

Petitioner was re-evaluated by Dr. Freitag on September 18, 2013. She reported the pain cream did not help; the doctor noted multiple modalities had been tried, including physical therapy, epidural steroid injection, trigger point injection, topical cream, and oral pain medication, but all had failed. Examination revealed significant tenderness to palpation over the spinous processes L4 and L5 and right upper lumbar/lower thoracic area posteriorly with some fullness felt but no obvious tumor or lesion. Dr. Freitag provided a Spen quick draw brace, ordered a chest CT, and advised Petitioner to proceed with a second opinion. PX5. The chest CT was completed on September 24 and revealed no abnormalities in the chest or upper abdomen and no osseous abnormalities in the thoracic spine. PX4.

On October 28, 2013, a second Application for Adjustment of Claim was filed for the alleged January 20, 2013 date of accident. PX1. This claim was assigned number 13 WC 35260 and Petitioner was represented by Strong Law Office.

On October 30, 2013, Petitioner returned to Dr. Freitag and complained of low back and right thoracic pain rated at 10/10. The doctor summarized Petitioner's history of pain ever since a work injury nine months prior and failed conservative treatment including therapy, pain creams and oral medications. The doctor again noted previous imaging, including lumbar x-rays and MRI, as well as an EMG were all negative. Petitioner continued to complain of severe pain stating nothing made it better and everything made it worse. On examination, Dr. Freitag noted exquisite tenderness to palpation over the lumbar area in the midline that "appears out of proportion," tender to even the lightest of touch, and very tender to even light touch on right thoracic wall; range of motion was within normal limits. Diagnosing chronic low back pain of unknown origin, Dr. Freitag memorialized Petitioner continued to complain of disabling lower back pain without any physical exam findings and an extensive radiographic workup which had all been negative. As the doctor was unable to determine the cause of her continued pain and the family had requested a second opinion referral to Dr. Kube on the recommendation of her lawyer, Dr. Freitag provided the referral and authorized Petitioner off work. PX5.

The initial consultation with Dr. Kube of Prairie Spine & Pain Institute took place on November 7, 2013. With her husband translating, Petitioner complained of ongoing pain in her back and legs following a work injury where she lifted a mattress and felt a pull in the right side of her back. Examination findings included negative tension and provocative maneuvers; "pain, very sensitive in the bilateral SI joints and lumbosacral junction, very nonspecific as well"; and positive twist and hypersensitivity. Reviewing the imaging, Dr. Kube noted the x-rays showed very little degenerative change of any kind with good disc heights, no spondylolysis or spondylolisthesis, and the thoracic MRI did not demonstrate a substantial neurocompressive lesion or substantial degenerative condition that would fully explain the symptoms. Dr. Kube concluded Petitioner appeared to have either a SI joint problem or lumbosacral disorder; the doctor ordered a lumbar MRI and authorized Petitioner off work. PX11.

The updated lumbar MRI was completed on November 12, 2013. The radiologist's findings included vertebral body heights and disc heights well maintained at all levels, spinal canal and neural foramen widely patent, and a very small perineural cyst at the L2-3 neural foramen on the right. The impression was normal lumbar spine MRI. PX4.

On November 25, 2013, Petitioner returned to Dr. Kube to discuss the scan. Dr. Kube noted the MRI was "relatively clean" with no substantial degenerative disease in the discs, good disc height in all discs, good signal intensity in all discs, and no neurocompressive lesion; other than the perineural cyst, Dr. Kube "[did] not see a whole lot of excitement on the MRI." The doctor recommended injections. PX11.

On December 6, 2013, a motion to consolidate Petitioner's two claims was granted. A fee petition was also entered and continued.

Dr. Kube performed bilateral SI joint injections on March 17, 2014. PX11. When Petitioner followed up a week later, she reported the injections were of no benefit and she continued to have severe pain. Dr. Kube re-reviewed the MRI and again documented he saw no specific neurocompressive lesion, no substantial disc degeneration, and nothing he could point

directly to that he could reliably improve with any surgical intervention. The doctor discussed therapy but Petitioner advised even water therapy aggravated her pain. Indicating Petitioner was "essentially approaching MMI," Dr. Kube ordered an FCE, prescribed an anti-inflammatory and muscle relaxant, and kept Petitioner off work. PX6.

The FCE was originally set for April 21, 2014. Petitioner appeared at Memorial Industrial Rehab as scheduled however during pre-testing questioning, she reported chest pain with activity, dizziness, and a sensation of feeling like she was going to pass out/passing out. Dr. Kube's office was contacted and Petitioner was directed to obtain clearance from her primary care physician before completing testing. PX11. This was apparently done and the FCE was conducted on May 14, 2014, though Petitioner's results were not deemed valid. The therapist memorialized Petitioner "self-limited all functional testing, reporting inability to attempt or continue with testing due to subjective complaints of pain…No objective signs of maximal effort were noted during test items." Due to Petitioner's self-limiting performance, her true abilities and true limitations were undetermined. PX11.

On May 27, 2014, Petitioner returned to Dr. Kube to review the FCE. Dr. Kube discussed the FCE findings:

> Unfortunately, the evaluation talks about her self-limiting, but it does not go into a lot of detail, as far as in the detailed report. The results and the interpretation really do not have anything to tell me exactly whether or not there is any indication of what she could do. It talks about four-pound lifts. There is a lack of any kind of objective signs of maximal effort. There were multiple items that she refused to do secondary to pain; things such as stairs, standing and elevated work. There were inconsistencies even with her walk. I believe she is having pain. Her spouse, who is translating for her, indicates that she has passed out secondary to pain. I believe she is having some pain, but based upon the results of this study, I have to believe she could do more than what was demonstrated on this study, because this is what the study indicates.

Dr. Kube concluded having Petitioner lift over 35 pounds would likely be dangerous, given her body mechanics, but stated he did not have an objective reason to limit her more than that. The doctor discharged Petitioner at maximum medical improvement with a 35-pound permanent weight restriction. PX6.

On January 27, 2015, Petitioner returned to see Dr. Kube and complained of pain in her back and legs. After an examination, Dr. Kube noted he again reviewed the MRI, which was relatively normal. Dr. Kube recommended trigger point injections, which he administered. The doctor reiterated Petitioner was at maximum medical improvement but would likely require some degree of chronic pain management in the form of medications, intermittent trigger point injections, or intermittent physical therapy. PX6.

Petitioner next saw Dr. Kube on March 5, 2015 and once more complained of substantial pain in her back and leg. Dr. Kube again memorialized Petitioner was not a surgical candidate, noting her discs appeared well hydrated, the degenerative disease was only minimal, and he did

not think there was ample degeneration to have an aggravation constituting a need for surgery. Dr. Kube recommended maintaining the permanent 35-pound lifting restriction and using medication for long-term pain management. PX6.

On March 19, 2015, Petitioner returned to Prairie Spine & Pain Institute where she was evaluated by Derek Morrow, PA-C, to transition to a medication management protocol. Petitioner once again reported significant back pain and leg pain. PA Morrow reviewed the imaging and observed the "nerves have great room to exit the spine," there were no neurocompressive lesions, and the facet joints looked to have a significant amount of cartilage. PA Morrow further noted Petitioner's recent report of fainting due to pain during the FCE, indicating he did not know why that would happen. Petitioner's medications were refilled and PA Morrow also ordered a course of physical therapy. PX6.

The recommended therapy commenced at Memorial Industrial Rehab on March 25, 2015. The initial evaluation reflects Petitioner complained of constant centralized and right-sided low back pain which she rated at 10/10; she advised a heating pad or pain medications helped only very slightly but even then the pain remained a 10/10. PX11. Petitioner attended five therapy sessions over the next two weeks. The April 16, 2015 discharge summary documents Petitioner's subjective complaints of "10/10 pain in her back and if she could report 11/10 she would." Petitioner did not think therapy helped and reported the exercises increased her pain; she did not believe further therapy would be beneficial and the therapist agreed. PX11.

On April 23, 2015, Petitioner was re-evaluated by PA Morrow who noted Petitioner still had "a score of 100 for the back, 100 for the leg" and "nothing we are doing seems to be improving her"; Petitioner also reported new symptoms along her right flank and was requesting a referral for massage therapy. PA Morrow agreed to massage therapy and prescribed cyclobenzaprine for pain. PX6.

Petitioner attended a brief course of chiropractic care at Chatham Chiropractic from April 27, 2015 through May 2, 2015. PX12. Petitioner has not had any treatment since. T. 14.

Petitioner testified she remained off work until she started working a part-time position at LaQuinta in March of 2016. T. 15, 24. This job does not require heavy lifting. T. 16, 18. She explained she works with her 21 year-old daughter and Petitioner only cleans bathrooms. T. 15. Petitioner testified she is the only employee at LaQuinta who only cleans bathrooms. T. 20.

As to her current symptoms, Petitioner testified she has not seen any improvement: "It's actually even worse. The pain is starting to go even lower now to my collarbone and it's inflamed all the time." T. 14. She stated if she sits for more than 30 minutes, "I think that I am going to faint because it hurts so much." T. 16. The pain goes from the upper back all the way down. T. 17. She is unable to use stairs because "it just hurts too much." T. 17-18. She takes ibuprofen for the pain. T. 18.

The January 31, 2014 evidence deposition of Dr. Kevin Rutz was admitted as Respondent's Exhibit 3. Dr. Rutz is a board certified orthopedic surgeon specializing in spinal surgery. RX3, p. 5. Dr. Rutz testified 95% of the Section 12 exams he does are at the request of

respondents. RX3, p. 18.

Dr. Rutz testified he does not believe Petitioner's condition was related to the alleged injury of January 20, 2013. RX3, p. 14. The doctor then explained the basis for his opinion:

> First, there is significant inconsistency in the medical records about the onset of her symptoms where in the earlier records it pointed to them starting at home. And there's various timelines that don't make sense meaning that in the notes from the ER on 1/25/13, which was five days after the alleged injury, part of the record notes pain started 10 days previously and part of the notes noted it was 15 days previously. So that was inconsistent. Putting that to the side, even if the mechanism of injury does not correlate with causing an injury to the spine, simply bending over and tucking in, lifting up a mattress part way to tuck in a sheet doesn't - - is an activity of daily living and I don't consider that an overstress on the spine that would cause an injury. And then third, there's a lack of objective findings on her scans that can account for her symptoms. And then she demonstrated - - my other concern was her nonphysiologic behavior meaning that she - - her symptom magnification gave me concern about the validity of how much of a problem she actually had. So there were these large subjective symptoms that had no physiologic basis and objective MRI findings and X-ray findings that demonstrated no signs of a problem. And, therefore, when putting all these things together, I don't believe that January 20th, 2013, any of the alleged event of lifting up the corner of a mattress caused the problem that she was seen before that day. RX3, p. 14-15.

Dr. Rutz further testified Petitioner could work without restrictions and the issue of maximum medical improvement was moot because there was no work injury. RX3, p. 16.

On cross-examination, Dr. Rutz stated Petitioner reported, either through her husband or the interpreter, that she injured herself when she bent down to pick up a mattress halfway up and that's when she felt pain. RX3, p. 19-20. Dr. Rutz testified he did not ask about the size of the mattress, nor did he ask what the mattress weighed. RX3, p. 20. As to what "halfway up" meant, Dr. Rutz stated the "impression I had in saying that was it was basically lifting part of one side so that she could tuck in the sheets"; the doctor testified it was described to him that she was picking up the mattress to tuck in a sheet. RX3, p. 20. Dr. Rutz was then asked to locate that in his report, as the only indication of tucking in a sheet in his report refers to another incident a few days after the January 20, 2013 incident; the doctor responded he could not remember. RX3, p. 20. The doctor thereafter agreed the information he had about lifting the mattress to tuck in a sheet was several days later. RX3, p. 21.

Dr. Rutz testified the pre-accident records he reviewed did not demonstrate complaints of back pain. RX3, p. 21-22. The doctor then confirmed he was not provided with any medical records showing Petitioner had any injury to her back before January 20, 2013. RX3, p. 22. Dr. Rutz clarified he only received an MRI order from Dr. Freitag's office; he was not provided with Dr. Freitag's medical records. RX3, p. 23.

Dr. Rutz was then directed to his statement and opinion that the activity of lifting a mattress is a daily living activity. The doctor agreed it was part of his opinion that because lifting a mattress is a daily living activity, he does not feel Petitioner had a work-related injury. RX3, p. 28. Asked whether the ultimate determination of whether lifting a mattress constitutes a work-related injury is up to the Commission, Dr. Rutz disagreed. RX3, p. 29. The doctor further stated that as part of his evaluation he was asked to give an opinion as to whether or not Petitioner sustained a work-related accident. RX3, p. 29. Dr. Rutz testified he is commonly asked to render accident opinions in his Section 12 exams and he routinely does so. RX3, p. 30. Directed to the next statement in his report wherein he opined Petitioner would have had the same problem regardless of whether or not she bent over to pick up the corner of the mattress, Dr. Rutz agreed he did not have any medical records showing Petitioner had problems with her back picking up mattresses before January 20, 2013. RX3, p. 30. Dr. Rutz further agreed complaints of low back pain do not appear in the medical records until after January 20, 2013. RX3, p. 31.

CONCLUSIONS OF LAW:

Preliminary issue

At arbitration, prior to taking evidence, there was an oral motion to dismiss 13 WC 05780, which the Arbitrator granted. The Commission wishes to make clear Mr. Danz's fee petition was not dismissed and it remains pending with the connected case 13 WC 35260.

I. Accident

To recover benefits under the Act, a claimant bears the burden of proving by a preponderance of the evidence that she sustained an accidental injury arising out of and in the course of her employment. 820 ILCS 305/1(d). Both elements must be present to justify compensation. *First Cash Financial Services v. Industrial Commission*, 367 Ill. App. 3d 102, 105, 853 N.E.2d 799 (2006). The "in the course of employment" element refers to the time, place, and circumstances surrounding the injury. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E.2d 665 (2003). "The 'arising out of' component is primarily concerned with causal connection" and is satisfied when the claimant has "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." *Id.* "There are three types of risks to which employees may be exposed: (1) risks that are distinctly associated with employment; (2) risks that are personal to the employee, such as idiopathic falls; and (3) neutral risks that do not have any particular employment or personal characteristics. [Citation.]" *Adcock v. Illinois Workers' Compensation Commission*, 2015 IL App (2d) 130884WC, ¶31, 38 N.E.3d 587.

Petitioner alleges she sustained a work-related back injury while lifting a heavy mattress on January 20, 2013. T. 8, 20. In challenging accident, Respondent emphasizes the multiple accident dates noted in the medical records and argues the inconsistencies in Petitioner's testimony and lack of corroboration in the medical records preclude a finding that Petitioner sustained an accidental injury arising out of and in the course of her employment. The Commission disagrees.

The Commission is cognizant of the multiple accident dates documented in the initial treating records however we do not find this fatal to Petitioner's claim. To be clear, communication barriers are repeatedly documented throughout the medical records. All the records reflect Petitioner spoke no English and relied on family members to communicate with the providers. While certainly there are variations noted as to the exact accident date, the Commission finds the salient detail consistently documented in the medical records is an onset of symptoms while lifting a heavy mattress:

> January 25, 2013 Memorial Medical Center – complains of back pain starting 15 days, patient was lifting a mattress and had back pain afterwards (PX4);
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> January 31, 2013 Memorial Medical Center – complains of low back pain x [two] weeks, husband states patient is housekeeper and began complaining of pain after lifting mattresses at work (PX4);
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> February 12, 2013 Memorial Medical Center – through translator: patient states she injured her back lifting a heavy mattress (PX4);
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> April 23, 2013 SIU Healthcare – her father reports she was injured on the job as a housekeeper, and states that while picking up a mattress she felt a strain on her back, and since that time she has continued to have discomfort; injury happened on [January 20, 2013] (PX5);
>
> June 19, 2013 Memorial SpineWorks Pain Center – she worked as a maid in hotel; during process of changing bed linens she was picking up the mattress and moving it around and hurt her back (PX4);
>
> July 31, 2013 Dr. Per Freitag – states she was lifting heavy mattresses on [January 20, 2013] when she noticed sudden onset of pain localized to her right mid back (PX5); and
>
> November 7, 2013 Dr. Richard Kube – when she was lifting a mattress at work there was a pull in the right side of her back (PX11).

The Commission observes there is one notation that the incident happened at home (the January 25, 2013 emergency room note lists location of incident as home) however this is inconsistent with the cover sheet for that date of service, which reflects it was an employment related injury, and the record was subsequently amended to reflect the injury occurred at work. Moreover, the Form 45 prepared by Andrea Sanders, the owner of the company, documents a January 20, 2013 accident: back pain from lifting, cleaning in hotel room. PX2.

Petitioner worked as a hotel housekeeper. Her cleaning duties required her to lift thick mattresses. While performing that specific job task, Petitioner sustained a back injury. As Petitioner's injury originated in an employment risk, *i.e.* lifting a heavy mattress while cleaning a hotel room, the Commission finds her January 20, 2013 accidental injury arose out of and in the course of her employment.

II. Causal Connection

To obtain compensation under the Act, "a claimant need prove only that some act or phase of his or her employment was a causative factor in his or her ensuing injury." *Vogel v. Industrial Commission*, 354 Ill. App. 3d 780, 786, 821 N.E.2d 807 (2005). In suggesting Petitioner failed to prove a causal connection between her alleged accident and her condition of ill-being, Respondent argues Dr. Rutz concluded there was no causation and his was the only medical opinion. The law is clear, however, that while the sole medical opinion may not be arbitrarily rejected, it is not binding on the Commission simply by virtue of the fact it is the sole medical opinion. *Kraft General Foods v. Industrial Commission*, 287 Ill. App. 3d 526, 532, 678 N.E.2d 1250 (1997). The Commission notes Dr. Rutz denied causal connection based in part on his conclusion there was no work accident because lifting the mattress was "basically an activity of daily living." RX3, p. 28. The nature of the risk to which a claimant is exposed and whether a claimant sustained a compensable accident are legal conclusions within the exclusive province of the Commission and well beyond Dr. Rutz's expertise. As such, we find Dr. Rutz's causation denial is diminished.

Moreover, "medical evidence is not an essential ingredient to support the conclusion of the Industrial Commission 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." *International Harvester v. Industrial Commission*, 93 Ill. 2d 59, 63-64, 442 N.E.2d 908 (1982). The Commission finds the record is consistent with causation based on a chain of events theory. Petitioner testified she had no prior back symptoms or problems and Dr. Rutz conceded Petitioner's pre-accident medical records are devoid of any mention of back treatment. The Commission therefore finds the record demonstrates a previous condition of good health. Moreover, the medical records consistently document an acute onset of back pain after lifting a heavy mattress after which the treating physicians concluded Petitioner suffered from various low back maladies. The Commission finds the chain of events establishes a causal relationship between the mattress lifting incident and Petitioner's low back condition of ill-being. The Commission further finds Petitioner reached maximum medical improvement as of August 13, 2013.

The Commission observes Petitioner continues to complain of unremitting 10/10 pain which has been unaffected by any treatment modality. At trial, Petitioner testified her condition is so dire that simply sitting for more than 30 minutes exacerbates her pain such that it leaves her feeling faint. T. 18. Yet despite extensive diagnostic workup with x-rays, multiple MRI scans, and an EMG, there is no credible objective evidence of pathology to corroborate her complaints. On October 30, 2013, Dr. Freitag noted Petitioner "continued to complain of disabling lower back pain without any physical exam findings and an extensive radiographic workup which have all been negative." PX5. Dr. Kube reviewed and re-reviewed the November 2013 MRI four times and repeatedly concluded the scan was relatively normal. PX11. PA Morrow also read the images and stated the nerves had "great room to exit the spine" and there were no neurocompressive lesions. PX6. The Commission further notes the treating records show evidence of symptom magnification, with Dr. Freitag observing Petitioner's exam complaints of

exquisite tenderness were "out of proportion," as well as the invalid FCE due to self-limiting behavior. Moreover, although Dr. Rutz's conclusions on what constitutes an accidental injury under the Act are not probative, the doctor's exam findings are relevant evidence of Petitioner's physical condition. Dr. Rutz noted Petitioner's discomfort "was fairly exaggerated on exam," she displayed symptom magnification (overreaction and superficial tenderness), her symptoms were in a non-physiologic distribution, there was a "profound lack of any pathology in her lumbar spine," as well as a lack of objective findings to correlate with her subjective complaints. The Commission finds Dr. Rutz's findings are wholly consistent with the treating physicians' inability to identify a pathological source for Petitioner's ongoing 10/10 pain. We also recognize, however, that Dr. Rutz concluded a thoracic spine MRI would be appropriate to complete the diagnostic workup. The thoracic spine MRI was performed on August 13, 2013 and was deemed a normal study.

The Commission finds Petitioner's ongoing complaints of disabling pain are not supported by the medical evidence and are not believable. Rather, the evidence is consistent with Petitioner having sustained a minor back injury which reached maximum medical improvement as of August 13, 2013.

III. Temporary Disability

To be entitled to Temporary Total Disability benefits, it is the claimant's burden to prove not only that she did not work but also that she was unable to work. *Shafer v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100505WC, ¶45, 976 N.E.2d 1. "Therefore, when determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disabled as a result of a work-related injury and whether the employee is capable of returning to the work force." *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 236 Ill. 2d 132, 146, 923 N.E.2d 266 (2010).

The record reflects Petitioner was first authorized off work on February 12, 2013. Although Dr. Rutz's June 27, 2013 Section 12 report does not include an assessment of Petitioner's work capacity (the doctor indicated the issue was moot because he felt there was no work injury), the doctor testified his examination of that date revealed Petitioner could work without restrictions. RX3, p. 16. The Commission finds Dr. Rutz's conclusion to be persuasive as it is consistent with Petitioner's negative diagnostic workup.

The Commission concludes Dr. Rutz's examination findings and testimony evidence Petitioner was capable of returning to the work force as of the date of his Section 12 examination. The Commission finds Petitioner is entitled to 19 3/7 weeks of Temporary Total Disability benefits, representing February 12, 2013 through June 27, 2013.

IV. Medical

Petitioner offered into evidence medical bills totaling $67,950.69. PX13. Initially, the Commission notes Petitioner's Exhibit 13 includes bills for unrelated treatment on the following dates of service: February 15, 2013 - Memorial Medical Center ($1,136.00); February 19, 2013 – Memorial Medical Center ($3,928.00); and February 19, 2013 – Pathology Associates of Central

Illinois ($311.00). These charges are for mammography and a biopsy, both clearly unrelated to Petitioner's accidental injury, and are denied.

The Commission finds the remaining medical services provided from January 25, 2013 through June 27, 2013, as well as the thoracic spine MRI performed on August 13, 2013, are reasonable and necessary under Section 8(a). Respondent shall pay the expenses associated with those services, subject to Section 8.2. Respondent shall also reimburse Petitioner for co-pays. Respondent shall have credit for any amounts previously paid.

V. Permanent Disability

Petitioner's work accident occurred after September 1, 2011; therefore, Section 8.1b is applicable. Section 8.1b(b) requires permanent partial disability be determined following consideration of five factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. 820 ILCS 305/8.1b(b).

Section 8.1b(b)(i) – §8.1b(a) impairment report

Neither party submitted a §8.1b(a) impairment report. As an impairment report is not a prerequisite to an award of permanent partial disability benefits (*Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶47, 56 N.E.3d 1101), the Commission will assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner returned to her pre-accident job as a housekeeper, albeit with a new employer, however she testified she does not perform the heavy lifting duties usually associated therewith. Instead, Petitioner works with her daughter and Petitioner is solely responsible for cleaning bathrooms. The Commission finds this weighs in favor of increased permanent disability.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 39 years old on the date of her accidental injury. Petitioner will therefore face any residual disability for a longer period. The Commission finds this factor weighs in favor of increased permanent disability.

Section 8.1b(b)(iv) - future earning capacity

Petitioner testified she currently works part-time at LaQuinta. However, she did not testify as to why she is not full-time nor as to her earnings, so there is no direct evidence as to the impact on Petitioner's future earning capacity. The Commission finds this weighs in favor of reduced permanent disability.

18IWCC0366

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Petitioner testified to significant ongoing complaints. As detailed above, however, the medical records do not contain objective findings to corroborate Petitioner's proclamations of severe disability. To the contrary, the medical records demonstrate predominantly negative diagnostic workup coupled with symptom magnification. The Commission finds this factor weighs heavily in favor of decreased permanent disability.

Based on the above, the Commission finds Petitioner sustained permanent partial disability to the extent of 3% loss of use of the person as a whole under Section 8(d)2.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $217.50 per week for a period of 19 3/7 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 $217.50 per week for a period of 15 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 3% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses under §§8(a) and 8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,700.00. 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 1 1 2018

L. Elizabeth Coppoletti

LEC/mck

O: 4/11/18

43

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GOMEZ, LESBIA
Employee/Petitioner

Case# **13WC035260**

SANDERS, ANDREA DBA SUPERIOR LABORER SERVICES
Employer/Respondent

18IWCC0366

On 8/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
MICHAEL K BRANDOW
3100 N KNOXVILLE AVE
PEORIA, IL 61603

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

18IWCC0366

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

Lesbia Gomez
Employee/Petitioner

v.

Andrea Sanders dba Superior Laborer Services
Employer/Respondent

Case # 13WC 35260

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **June 15, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 1/20/2013, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $11,310.00; the average weekly wage was $217.50.

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

Petitioner *has not* received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $4,350.00 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 $4,419.20 under Section 8(j) of the Act.

ORDER

THE PARTIES STIPULATED AND THE ARBITRATOR ORDERS CLAIM 13WC5780 BE DISMISSED.

THE RESPONDENT SHALL PAY REASONABLE AND NECESSARY MEDICAL SERVICES AS PROVIDED IN SECTION 8(A) AND 8.2 OF THE ACT FROM JANUARY 20, 2013 THROUGH MAY 27, 2014, WHEN DR. KUBE PLACED THE PETITIONER AT MAXIMUM MEDICAL IMPROVEMENT.

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF $217.50/WEEK FOR 56 1/7 WEEKS, COMMENCING 1/21/2013 THROUGH 5/27/14 AS PROVIDED IN SECTION 8(A) OF THE ACT.

THE RESPONDENT SHALL PAY THE PETITIONER PERMANENT PARTIAL DISABILITY BENEFITS OF $217.50/WEEK FOR 25 WEEKS, BECAUSE THE INJURIES SUSTAINED CAUSED 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

8/27/17
Date

AUG 29 2017

Lesbia Gomez v. Hilton Hotels-Andrea Sanders d/b/a Superior Laborer Services
13 WC 35260

STATEMENT OF FACTS

The Petitioner, Lesbia Gomez, testified that she was hired by the Respondent on November 27, 2012, as a housekeeper. On January 20, 2013, while cleaning one of the rooms, she lifted a heavy mattress and noticed pain in her right upper back. The Petitioner continued to work the rest of the day. The Petitioner testified that she informed her employer on the date that this accident occurred. She went to Memorial Medical Center Emergency Room on January 25, 2013.At the emergency room, she reported tenderness at the lumbothoracic junction, with paraspinal muscle tenderness approximately 3 centimeters to the right of mid-line per the records. The history of present illness indicated that she was at the emergency room with her husband complaining of back pain starting 15 days ago while lifting a mattress and noticed back pain afterwards. It was noted that the patient did not speak English and the history was provided by her husband. The pain was described as being sharp. The Petitioner was diagnosed with a back strain.

On January 31, 2013, the medical records indicate that the Petitioner went to Memorial Medical Center Emergency Room once again complaining of pain after lifting mattresses at work. It was noted that she was given tramadol 6 days previously in the emergency room. It has been stated that the Toradol was not helping the pain. The Petitioner had right leg numbness but no groin numbness. She was able to walk without difficulty. It should be noted that on the cover sheets for the visits, the Petitioner reported on both occasions that this was a workers compensation claim and that it was employment related.

The Petitioner returned on February 12, 2013 to Memorial Medical Center with her husband again interpreting. He stated that the Petitioner injured her back while lifting a mattress at work on January 25, 2013, and she continues to have pain. It should be noted that the Petitioner was placed under restrictions of no heavy lifting for at least 10 days. Prior to this visit, the Petitioner was terminated on February 6, 2013 by the employer. Also, in the medical records of February 12, 2013, it was noted that emergency room nurse needed an interpreter for a Spanish speaking patient.

The Petitioner indicated that due to continuous back pain, she sought medical treatment at Central Counties Health Center, seeing Dr. Allamreddy. Dr. Allamreddy noted that the Petitioner had back pain and had been in the emergency room recently. Physical therapy was discussed and recommended. The Petitioner underwent the initial evaluation for physical therapy on March 7, 2013. The medical records indicated that the Petitioner reported pain along the right side of her spine from about the shoulder blade level down to the pelvis. She also reported pain in her low back and tingling to the right leg. The assessment section indicated that due to her pain, the Petitioner was unable to work as a housekeeper and it was limiting her daily activities. Therapy plan

was to be seen two times per week. On March 20, 2013, the Petitioner followed up with Dr. Allamreddy, who believed an MRI was necessary and also a referral to an orthopedic surgeon was in order.

The medical records of Dr. Allamreddy of April 24, 2013, indicated that the Petitioner saw an orthopedic specialist the previous day with aquatic physical therapy being recommended. The MRI of the lumbar spine was still being recommended. On May 1, 2013, the Petitioner underwent an MRI of the lumbar spine at St. John's Hospital. The impression was minimal degenerative changes, no disc herniation, no spinal stenosis and no foraminal stenosis at any level. The medical records indicate that the Petitioner continued with physical therapy.

On May 20, 2013, the Petitioner returned to see the physician assistant, Jacob Monsivais. The medical records from this visit contained information from family members that after two weeks of physical therapy, the Petitioner became worse and she continued to have discomfort. An examination took place with the impression being low back pain and sub-acute lumbar radiculopathy. An EMG was recommended. Injections were to be considered after the EMG was performed.

The nerve conduction study that was recommended occurred on June 10, 2013. The impression was a normal study with no evidence of lumbosacral radiculopathy. The Petitioner was referred to Memorial Spine Works and was examined by Dr. Salvicion. The Petitioner underwent a left epidural steroid injection with a diagnosis of lumbar degenerative disc disease, lumbar radiculopathy on June 28, 2013. She had another injection; that being a trigger point injection, right latissimus myofascial pain on July 12, 2013. The Petitioner reported no relief with either of the injections.

Prior to undergoing the injection, the Petitioner was examined by Dr. Kevin Rutz at the request of the Respondent. Dr. Rutz diagnosed with right lower thoracic and lumbar back pain. He did not believe that the current lumbar spine condition was related to a repetitive injury or a simple lifting incident. He stated that she simply bent over to lift the corner of a mattress and that is basically an activity of daily living. The Petitioner had testified that these mattresses are extremely heavy and he would lift these mattresses and turn them over. The doctor stated that the symptoms are in a non-physiologic distribution without any pathology in the lumbar spine as the symptoms seem somewhat magnified. As far as further treatment, he recommended an MRI of the thoracic spine.

On August 16, 2013, the Petitioner was still complaining of thoracic and low back pain. There was no relief from either injection. The treatment plan was for the Petitioner to follow up with Dr. Freitag. On August 26, 2013, the Petitioner was informed pursuant to a telephone call from her doctor that he could no longer keep off of work.

The Petitioner saw Dr. Hoffman on September 3, 2013, who referred her to Dr. Kube for a second opinion. Also, on September 18, 2013, the Petitioner saw Dr. Freitag

who ordered a CT of the abdomen and her chest to see if that would be the problem causing her pain and also referred her on to see Dr. Kube.

On October 30, 2013, Dr. Freitag indicated that the Petitioner has failed conservative treatment and that all diagnostic tests were negative. On November 7, 2013, the Petitioner saw Dr. Kube, who had taken her off work. Following his examination, he indicated that it appeared that she had an SI joint problem and ordered an MRI of the lumbar spine. Further, he provided her with an injection. Unfortunately, at a follow up visit on November 25, 2013, Dr. Kube stated that the SI joint injection did not help. He reviewed the MRI of the lumbar spine. Dr. Kube was of the opinion as of April 23, 2014, that he knew nothing that could make the Petitioner better. She had only minimal relief from the injection. The Petitioner requested massage therapy on April 23, 2014. Dr. Kube referred the Petitioner on for a functional capacity evaluation which took place on April 14, 2014. The functional capacity evaluation was declared invalid as the Petitioner was limiting her efforts per the report.

On May 27, 2014, Dr. Kube, after reviewing the FCE, indicated that the Petitioner could do more than the FCE indicated and provided a 35 lb. lifting restriction. He released her to return to her primary care doctor for treatment finding her at maximum medical improvement. The Petitioner has treated since then at Chatham Chiropractic from April 27, 2015 through May 2, 2015, with little relief.

As of the date of the hearing, the Petitioner indicated that she was once again back at work as a housekeeper. She does not do any heavy lifting as she works with her daughter and she describes her work as being mainly dusting and washing off the windows.

In support of the Arbitrator's decision relating to:

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

The cause of the injury to the Petitioner is clear. She was consistent throughout her treatment that she suffered an injury to her low back while lifting a heavy mattress. Some of the dates that are listed for the accident vary but are within 3 to 4 days of the January 20, 2013 accident date. I find that this could be attributed to the Petitioner being a Spanish speaking individual and her interpreter was providing information to the medical providers. I note also on this point that even if the accident occurred three or four days prior to the January 20, 2013 accident

date or a couple of days after, that the Petitioner was employed as a housekeeper during this whole time frame, turning the heavy mattresses was one of her duties. Therefore, I find that based upon the mechanism of the injury as described by the various medical providers and the testimony of the Petitioner that she was injured in an accident that arose out of and in the course of her employment by the Respondent.

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

From an overall review of the medical records, I find that the Petitioner suffered from an injury to the thoracic spine of her back. Her complaints of thoracic pain was consistent from the date of her injury on January 20, 2013 through the date of the hearing. She had other complaints which mostly involved the lumbar back area. I note that Dr. Kube explored an SI joint problem but that was never confirmed. Therefore, I find that her current condition of ill-being, that being a thoracic myofascial injury, was 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?

I find that the medical treatment received by the Petitioner through the time that she saw Dr. Kube was reasonable and necessary. Dr. Kube released the Petitioner stating that she was at maximum medical improvement effective May 27, 2014, with a 35 lb. lifting restriction. I find that all treatment rendered prior to this date were causally related to her accident and I order the Respondent to pay the same.

(K) What temporary benefits are in dispute? TTD

The Petitioner was injured on January 20, 2013. She had restrictions where she was kept off work consistently from that date through May 27, 2014, when Dr. Kube found that she was at maximum medical improvement. The Petitioner was not employed as she was terminated on February 6, 2013. As such, I find that according to the medical records and the testimony of the Petitioner, that the Petitioner was temporarily and totally disabled from January 21, 2013 through May 27, 2014.

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

I find that the Petitioner suffered a 5% loss of use of a man as a whole for her injury to the thoracic spine. I base my decision on the following:

1. No impairment rating was provided in this case;

2. The Petitioner's occupation at the time of the injury was a housekeeper;

3. The Petitioner was 39 years of age at the time of her injury;

4. The employee's future earning capacity has been impaired as she has been placed on permanent work restrictions by Dr. Kube.

5. The evidence of disability was corroborated by the medical records and the opinions of Dr. Kube.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Moran,

Petitioner,

vs. NO: 11 WC 39112

City of Chicago,

Respondent.

18IWCC0367

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner and notice provided to all parties, the Commission, after considering the sole issue of nature and extent of permanent disability and being advised of the facts and law, corrects a clerical error in the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects the clerical error on page 1 of the Arbitrator's Decision from Robert Williams to George J. Andros. Arbitrator Andros decided this case and issued his Decision on May 1, 2017. The Commission affirms and adopts Arbitrator Andros' Decision with this correction.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 1, 2017 is corrected for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 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 permanent disability of the person as a whole to the extent of 20%.

18IWCC0367

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

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

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.

JUN 11 2018

DATED:
LEC/maw
o05/23/18
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORAN, KEVIN
Employee/Petitioner

Case# **11WC039112**

CITY OF CHICAGO
Employer/Respondent

18IWCC0367

On 5/1/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0391 HEALY SCANLON
KEVIN T VEUGELER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

☐	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

KEVIN MORAN
Employee/Petitioner

Case #11 WC 39112

v.

CITY OF CHICAGO
Employer/Respondent

18IWCC0367

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by an arbitrator of the Workers' Compensation Commission, in the city of Chicago, on September 29, 2014. After reviewing all of the evidence presented, the Honorable Robert Williams 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 May 3, 2011, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $73,216.00; the average weekly wage was $1,408.00.
- At the time of injury, the petitioner was 56 years of age, married with no children under 18.
- The petitioner agreed that the respondent paid the appropriate amount for all the related, reasonable and necessary medical services provided to the petitioner.
- The parties agreed that the respondent would pay the $290.00 bill of Northwestern Orthopaedics and Sports Medicine pursuant to the fee schedule.
- The parties agreed that the respondent paid $80,192.67 for temporary total disability and maintenance benefits.
- The parties agreed that the petitioner is entitled to temporary total disability benefits for 57-5/7 weeks, from May 9, 2011, through June 15, 2012, and maintenance benefits for 27-2/7 weeks from June 16, 2012, through July 31, 2012, and from December 4, 2012, through April 30, 2013.

ORDER:

- The respondent shall pay the petitioner the sum of $669.64/week for a further period of 100 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 20% loss of use of the person for his left shoulder injury.

- The respondent shall pay the petitioner compensation that has accrued from May 3, 2011, through September 29, 2014, 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.

#001 George Andros May 1, 2017

MAY 1 - 2017

FINDINGS OF FACTS:

The petitioner, a right-handed heavy-duty laborer with the respondent's water department, sustained a left shoulder injury on May 3, 2011, after falling off a ladder. He began care at MercyWorks on May 6th and reported left shoulder pain and difficulty lifting his arm over his head. He was given medication and work restrictions for a left shoulder contusion. He received physical therapy from May 12th through June 6th. An MRI on June 14th revealed a large effusion at the glenohumeral joint, thickening of the distal portion of the supraspinatus tendon with a subtotal tear at its articular surface.

Dr. Christopher Mahr saw the petitioner on June 17th and noted a positive impingement sign. He opined that the MRI revealed a large full-thickness supraspinatus tendon tear. On July 6th, the petitioner had a left shoulder arthroscopic rotator cuff repair, debridement and a subacromial decompression by Dr. Mahr. Due to the petitioner's age, Dr. Mahr did not repair a degenerative anterior and posterior labral tear discovered during surgery. The petitioner retuned to restricted work on April 16, 2013, and continued following up with Dr. Mahr periodically through April 23, 2014. Dr. Mahr noted no pain complaints at the last follow-up and released the petitioner to full duties beginning May 1st. The petitioner had a full range in his shoulder motion and a 5/5 rotator cuff muscle strength in all the major muscle groups.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner complains of left arm pain, weakness, loss of function and sensitivity to temperature changes and dampness. The respondent shall pay the petitioner the sum of $669.64/week for a further period of 100 weeks, as provided in Section 8(d)2

of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 20% loss of use of the person for his left shoulder injury.

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

Dennis Maestas,
Petitioner,

vs.

NO: 16WC 19609

Illinois Department of Transportation,
Respondent.

18IWCC0368

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 November 6, 2017, is hereby affirmed and adopted.

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

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

No bond or summons required for State of Illinois cases.

DATED: JUN 11 2018
d062218
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MAESTAS, DENNIS
Employee/Petitioner

Case# **16WC019609**

IL DEPT OF TRANSPORTATION
Employer/Respondent

18IWCC0368

On 11/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0412 RIDGE & DOWNES
KARIN K CONNELLY
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

5705 ASSISTANT ATTORNEY GENERAL
CAITLIN PAPADOPOULOS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
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

NOV 6 - 2017

BRANDI A. HARRIS, Acting Secretary
Illinois Workers' Compensation Commission

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
NATURE AND EXTENT ONLY

Dennis Maestas
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # **12** WC **30480**

Consolidated cases: **N/A**

18IWCC0368

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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva**, on **September 11, 2017**. By stipulation, the parties agree:

On the date of accident, **June 2, 2016**, 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 **$54,080.00**, and the average weekly wage was **$1,040.00**.

At the time of injury, Petitioner was **47** years of age, ***married*** with **1** dependent child.

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

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

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

ORDER

As explained in the Arbitration Decision Addendum, based on the factors delineated in Section 8.1b of the Act, and the record taken as a whole, Respondent shall pay Petitioner permanent partial disability benefits of $624.00/week for 15.375 weeks, because the injury sustained caused permanent partial disability to the extent of 7.5% of the left hand, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from June 2, 2016 through September 11, 2017, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

October 31, 2017
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
NATURE AND EXTENT ONLY

Dennis Maestas
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # **12** WC **30480**

Consolidated cases: **N/A**

FINDINGS OF FACT

The only issue in dispute in this case is the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Dennis Maestas (Petitioner) testified that he is employed by Illinois Department of Transportation (Respondent) and has been so employed approximately 2½ - 3 years. Petitioner is currently employed as a Highway Maintainer. In this position, Petitioner testified that he took care of roadways picking up large debris, removing animal debris, mowing grass, etc. Petitioner testified that he is right-hand dominant.

On June 2, 2016, Petitioner was mowing the right of way on Route 68 using a John Deere tractor with a "half bat" mower blade. He explained that he was cutting grass standing five feet or taller with a mower powerful enough to cut down anything in its way and built for this specific need. Petitioner testified that he could not see a mattress spring in the ground through the tall grass, which he ran over shutting off the mower completely. He dismounted from the mower and saw that the mattress spring was entangled in the lower blades. Petitioner called the supervisor and took the mower to a repair shop. To remove the spring from the mower blade, Petitioner explained that he wrapped a hammer around the spring, but it broke causing his left middle, ring and pinky fingers to hit the mower's metal guard that prevents rocks and other debris from flying out when in use. Petitioner testified that he felt tingling and immediate pain that was agonizing. He took off his glove and his pinky nail was completely black and blue. Petitioner put the glove back on and he removed the spring from the mower. Petitioner reported the accident and he went back to work. However, the following day with worsening symptoms, Petitioner went to an urgent care center.

The medical records reflect that Petitioner presented at Fox Valley Orthopaedic Institute and saw Craig Torosian, M.D. (Dr. Torosian) on July 8, 2016. PX1. Dr. Torosian noted a consistent mechanism of injury and post-accident treatment including drainage of a subungual hematoma and splinting incorporating the PIP joint. *Id.* Dr. Torosian diagnosed Petitioner with a laceration, subungual hematoma status post drainage of distal phalanx fracture with arthrofibrosis of the PIP and DIP joints of D3, D4 and D5. *Id.* He ordered physical therapy and imposed work restrictions. *Id.*

Petitioner underwent the recommended physical and occupational therapy from July 12, 2016 through August 17, 2016. PX2. On August 29, 2016 Petitioner was discharged from occupational therapy after a total of eighteen visits. *Id.* Petitioner testified that he did not cancel his final two appointments and explained that Dr. Torosian told him to stop going to occupational therapy.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

Petitioner returned to Dr. Torosian on August 22, 2016 reporting some stiffness, pain weakness, and sensitivity. PX1. He was also still working on flexion of the left ring and small fingers with constant small finger tip numbness. *Id.* Dr. Torosian noted that Petitioner was nearly able to make a full composite fist and could extend fully. *Id.* He also indicated that Petitioner's nailbed hematoma was resolving although he had mild tenderness about the distal phalanx. *Id.*

Petitioner last saw Dr. Torosian on October 24, 2016 reporting stiffness in the left hand with decreased grip strength, rom, occasional sharp pain while lifting and pulling heavy objects, and numbness and tingling mainly in the mornings. *Id.* Dr. Torosian determined that Petitioner was at maximum medical improvement and released him back to work regular duty. *Id.* Dr. Torosian also noted that the "[r]esidual effects of this injury include weakness, pain, stiffness, and lack of flexibility as well as sensitivity of the tips." *Id.* Petitioner testified that he returned to work full duty after his release by Dr. Torosian.

No impairment rating pursuant to the AMA Guides was submitted into evidence by either party. Regarding his current condition of ill-being, Petitioner testified that he feels throbbing and pain daily. He also has a hard time using a chain saw and hand tools. To compensate, Petitioner testified that he pulls using his wrist or he pushes using his left palm. He also has difficulty gripping and weakness compared to his pre-accident condition. Petitioner explained that he uses his right hand to lift items, but if is a small item that he needs to pick up, he uses his index finger. Occasionally, Petitioner takes over-the-counter Advil to alleviate his pain. Petitioner testified that he is earning the same amount of money he earned before his accident.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. In assessing the nature and extent of Petitioner's injury, the Arbitrator notes the following:

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

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

Considering these factors in light of the evidence submitted at the hearing, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report was offered into evidence. Thus, the Arbitrator assigns no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a full time Highway Maintainer the time of his accident and remains so employed. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 47 years old at the time of the accident. This fact is stipulated by the parties. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), the future earning capacity of the employee, the Arbitrator notes that there was no evidence of any diminishment in Petitioner's future earnings capacity as a result of the accident. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained an undisputed accident causing a laceration, subungual hematoma requiring drainage, and distal phalanx fracture with arthrofibrosis of the PIP and DIP joints of D3, D4 and D5 in the non-dominant left hand. Petitioner's treatment thereafter included physical and occupational therapy. At the time of his last treatment, Dr. Torosian noted that Petitioner had "weakness, pain, stiffness, and lack of flexibility as well as sensitivity of the [affected finger] tips[,]" which is consistent with Petitioner's testimony at the hearing of continued symptomatology including daily pain and throbbing, difficulty gripping and weakness compared to his pre-accident condition, difficulty using work tools including a chain saw, and compensating with other digits in the hand or his other hand or wrists for the weakness and gripping difficulties. Thus, the Arbitrator assigns significant weight to this factor.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 7.5% of the left hand, as provided in Section 8(e) of the Act.

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

Valerie Denison,
Petitioner,
vs.

NO: 15WC 38106
16WC 31065

18IWCC0369

Illinois State University,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 30, 2017, is hereby affirmed and adopted.

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

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

DATED: JUN 11 2018

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

o060418
KWL/jrc
042

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DENISON, VALERIE
Employee/Petitioner

Case# **15WC038106**

16WC031065

ILLINOIS STATE UNIVERSITY
Employer/Respondent

18IWCC0369

On 11/30/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
JEAN A SWEE
2011 FOX CREEK RD
SPRINGFIELD, IL 61701

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

0988 ASSISTANT ATTORNEY GENERAL
JORDAN A HOMER
500 S SECOND ST
SPRINGFIELD, IL 62706

0903 ILLINOIS STATE UNIVERSITY
1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

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

NOV 30 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

VALERIE DENISON,
Employee/Petitioner

v.

ILLINOIS STATE UNIVERSITY,
Employer/Respondent

Case # 15 WC 38106

Consolidated cases: 16 WC 31065

18IWCC0369

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Bloomington** , on **10/25/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/25/15**, 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 **$32,058.00**; the average weekly wage was **$616.50**.

On the date of accident, Petitioner was **42** 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 **$21,079.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$21,079.00**. Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $411.00/week for 54-5/7 weeks, commencing 11/16/15 through 12/5/16, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services from 8/25/15 through 3/9/17 for her right elbow, 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 partial disability benefits of $369.90/week for 31.625 weeks, because the injuries sustained caused the 12.5% loss of the right 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.

Signature of Arbitrator

11/12/17
Date

ICArbDec p. 2

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 42 year old building service worker, alleges she sustained either a specific trauma injury (15 WC 38106) or repetitive work injury (16 WC 31065), that arose out of and in the course of her employment on 8/25/15. Respondent did not object to petitioner pursuing both theories for the same date of accident.

Prior to 8/25/15 petitioner had worked for respondent for five years as a building service worker. Petitioner's duties included cleaning bathrooms, scrubbing showers, scrubbing sinks, scrubbing walls, vacuuming, wiping down shower stalls, mopping and sweeping floors, and cleaning and wiping down furniture in the dorm rooms. Petitioner would clean 12 bathrooms a shift. Each bathroom had two showers, two toilets, and two sinks. Petitioner testified that she constantly used her hands and arms daily.

On 8/25/15 while in the shower mopping the shower floor with a scrub brush that was attached to a pole, petitioner injured her right elbow, when she turned and struck her right elbow with some force against the shower stall. Petitioner experienced immediate pain in her right elbow, as well as swelling and bruising about the right elbow. She testified that it hurt to do anything with her arm. Petitioner reported the injury immediately after it occurred.

Petitioner was sent by respondent to OSF Occupational Health Network and was seen by Dr. Chow. Petitioner provided a consistent history of the injury. She complained of pain with movement of her right elbow. She denied any numbness or tingling in her fingers. An examination revealed bruising and swelling about the right elbow. An x-ray of the right elbow revealed no fracture or dislocation; normal bone mineralization; no abnormality of the soft tissues; and no elbow joint fusion. Petitioner was assessed with an elbow contusion. She was told to ice it for the next 48 to 72 hours, and take some Aleve. She was given a right elbow soft brace for support. She was instructed to return three days later.

On 8/27/15 petitioner completed an accident report. She gave a history of mopping the shower floor and hitting her right elbow on the door jam.

Petitioner returned to OSF Occupational Health Network on 8/28/15 and saw Dr. Chow. She reported that her right elbow hurt less than it did on her last visit. She reported that although she could move it more the movement was associated with pain. Petitioner reported tingling in the morning when she awakes, that improves after a while. An examination revealed tenderness about the lateral epicondyle, and swelling and bruising around the lateral epicondyle area. Petitioner had tenderness with forced extension. Petitioner was assessed with a right elbow contusion and right elbow tendinitis. She was given a prescription for prednisone, and was also prescribed a left elbow compression sleeve. She was released to work with restrictions on

pulling/pushing/lifting/gripping/twisting more than 5 pounds with her right hand, as well as a restriction on repetitive movements in awkward positions with the right elbow.

On 9/8/15 petitioner returned to Dr. Chow. She reported that she was wearing her elbow sleeve, but not the right one. She stated that she awakens at night with increased pain in her right elbow. She still noted some bruising around the right elbow. Dr. Chow examined petitioner and noted that her elbow condition was unchanged, and that her elbow was warm to the touch. Petitioner stated that the prednisone only helped a little. Petitioner's swelling in her right elbow had decreased a little. Dr. Chow gave her a script for a custom elbow sleeve which petitioner eventually got. Dr. Chow's diagnosis and restrictions remained the same. She also referred petitioner to occupational therapy.

Petitioner followed up at OSF Occupational Health Network on 9/28/15, 10/9/15, and 10/26/15. During this timeframe petitioner's condition improved slightly. However, on 10/26/15 Dr. Chow still had petitioner restricted to no pulling/pushing/lifting/gripping/twisting more than 10 pounds with the right hand. She was also still restricted from repetitive movements in awkward positions with her right elbow.

On 10/30/15 petitioner last followed up with Dr. Chow. She reported more pain in her right elbow due to decreased restrictions and more mopping at work. She stated that occupational therapy helped for a while. She stated that her elbow sleeve caused swelling due to the compression. An examination revealed decreased grip strength, and her right elbow was swollen and tender. Her range of motion was also limited. Dr. Chow transferred petitioner's care to Dr. Jerome Oakey. Petitioner was released to work with the same restrictions.

On 11/4/15 petitioner was discharged from occupational therapy. At that time she stated that she had a lot of pain the prior night and was continuing to have elbow pain. She reported that the day prior she noticed a small dark red discoloration at the right elbow, which was where the iontophoresis treatments were performed. The therapist noted that petitioner had made little to no progress with regards to her pain and strength.

On 11/9/15 petitioner presented to Dr. Jerome Oakey. Her primary complaint was her right elbow. Petitioner provided a consistent history of the accident on 8/25/15 when she hit her right elbow on a shower stall. She reported that her general use of the right upper extremity was painful. She reported radiating pain down into her hands with associated numbness and tingling. Petitioner reported temporary relief of her symptoms while in therapy. She stated that once the therapy was completed her pain returned. Petitioner reported weakness in the right upper extremity. Dr. Oakey examined petitioner and assessed right lateral elbow pain. He was of the opinion that this most likely represented lateral epicondylitis, or tennis elbow, and it began with a traumatic event. He was further of the opinion that petitioner had some loss of soft tissue. It was unclear

to him if this was a tendon or subcutaneous tissue. Dr. Oakey ordered an MRI and restricted petitioner to 1lb use of her right arm.

On 11/13/15 petitioner had Dr. Oakey complete an FMLA Certification of Health Care Provider for Employee. Dr. Oakey noted that petitioner was restricted from lifting more than 1 pound with her right upper extremity, and that she must wear her wrist splint. His diagnosis included right lateral elbow pain and lateral epicondylitis.

On 11/24/15 petitioner underwent an MRI of her right elbow. The impression was partial tear of the common extensor tendon with no full thickness tear or tendon retraction.

Petitioner returned to Dr. Oakey on 12/9/15. She continued to report severe right lateral epicondyle pain. Dr. Oakey was of the opinion that this was associated with loss of subcutaneous fat and skin discoloration from previous modalities. Petitioner reported that her pain was aggravated with use, and worse at night. Dr. Oakey noted that the MRI performed 11/24/15 suggested partial thickness tear involving approximately 70% of the tendon thickness. No tendon retraction was noted. Based on these results, he performed a steroid injection into petitioner's right lateral condyle. Dr. Oakey gave her restrictions of 1 pound use with the right-hand, and use of her splint.

On 1/6/16 petitioner presented to Crystal Sweeney, a nurse practitioner at Dr. Oakey's office. Petitioner stated that she was still using her brace and had 50% relief following the injection. She stated that her sleeping continued to be difficult due to positioning. Sweeney released petitioner to work with the same restrictions.

On 1/11/16 petitioner began another course of occupational therapy recommended by Dr. Oakey.

On 2/8/16 petitioner returned to Dr. Oakey. She told Dr. Oakey that her relief was only temporary following the injection. He noted that petitioner had associated soft tissue loss from steroids that were administered in physical therapy. Petitioner reported that her pain was a severe ache at the lateral aspect that worsens when she grips anything. Dr. Oakey and petitioner discussed her options for treatment given the fact that she had failed conservative treatment. Dr. Oakey noted that the next step would be a right lateral epicondylar debridement and repair. Dr. Oakey left petitioner's restrictions unchanged.

On 3/7/16 petitioner presented to Crystal Sweeney at Dr. Oakey's office. Petitioner reported that her symptoms were unchanged. She stated that she was unable to lift a coffee cup without increased pain. She stated that any prolonged activity with her right hand made her right hand symptomatic. She stated that pain wakes her at night, but she continues to wear her brace. Sweeney noted that they had submitted their request for

surgery to workers' comp and they were still awaiting a response. Sweeney released petitioner with the same restrictions.

On 6/14/16 petitioner presented to Dr. Sudekum for a Section 12 examination at the request of the respondent. Petitioner provided a history of mopping the floor of the shower stall at work, and striking her right elbow on the divider between the two stalls. She stated that she experienced immediate pain in her right lateral elbow, and had some transient numbness and tingling in the fingers of her right hand. Dr. Sudekum reviewed medical records that included an x-ray performed 8/25/15, the accident report completed 8/27/15, the occupational therapy note of 9/21/15, the MRI of the right elbow performed 11/24/15, and the report of Dr. Oakey dated 12/8/15. Petitioner's current complaints included pain in her right lateral elbow and forearm with use and at rest. She also complained of pain at night and occasional tingling to her fingertips if her elbow is resting on something. She reported that her right lateral elbow pain was worse with elbow extension and lifting. She also felt that her right elbow range of motion was limited, and her right upper extremity strength was decreased. Dr. Sudekum performed a physical examination.

Dr. Sudekum was of the opinion that lateral epicondylitis is a very common chronic degenerative condition that develops over a period of many months or years, and is often associated with arthritis, calcific tendinitis, and/or sustained repetitive strenuous upper extremity activities. Dr. Sudekum noted that petitioner's verbal chronology of the onset of her symptoms suggests that her right lateral epicondylitis developed acutely as a result of an injury on 8/25/15. He further added that petitioner's statement regarding the acute onset of her symptoms without any precursor symptoms would suggest that there was no pre-existing condition affecting the right elbow, specifically right lateral epicondylitis, prior to 8/25/15. However, Dr. Sudekum was of the opinion that it is important to note that the x-rays obtained by Dr. Oakey and himself, both reveal calcifications in the region of the right lateral epicondyle, consistent with chronic calcific tendinitis and lateral epicondylitis which would have preexisted the 8/25/15 date of injury. Dr. Sudekum was of the opinion that the medical records that he reviewed did not reveal any evidence of acute soft tissue injury to her right upper extremity as a result of the 8/25/15 incident. Dr. Sudekum was of the opinion that a much more common and likely scenario, other than an acute onset of lateral epicondylitis after a relatively minor traumatic injury or contusion such as that described by petitioner, would be that she had pre-existing calcific tendinitis and lateral epicondylitis. He was further of the opinion that it is possible and likely that petitioner may have experienced some pain in the lateral elbow when she struck her elbow while mopping, especially if petitioner did suffer from pre-existing chronic right lateral epicondylitis. Dr. Sudekum was of the opinion that since the x-ray of 8/25/15 revealed no soft tissue abnormality or elbow joint effusion that it is more likely than not that petitioner did not sustain a significant

acute soft tissue injury. Dr. Sudekum also was of the opinion that there was no indication on the MRI scan that there was any significant soft tissue swelling or effusion of the elbow. He believed this finding was also consistent with mild chronic right lateral epicondylitis. Dr. Sudekum was of the opinion that petitioner's subcutaneous atrophy noted on his examination of her was not due to the primary condition or pathology associated with lateral epicondylitis itself, but is a treatment affected due to the steroid iontophoresis performed at therapy and/or the steroid injection administered by Dr. Oakey. Dr. Sudekum was of the opinion that petitioner's subjective symptoms were out of proportion to his objective findings on physical examination and the imaging studies performed at the Missouri Hand Center. Dr. Sudekum's diagnosis was subjective symptoms and complaints consistent with moderate chronic right lateral epicondylitis; imaging studies that reveal objective evidence of mild chronic right lateral epicondylitis and chronic calcific tendinitis; and possible symptom magnification. He was of the opinion that petitioner had some pre-existing, non-work related risk factors and/or comorbid conditions which could predispose her to develop lateral epicondylitis in her dominant right elbow regardless of her employment activities and/or work related injury. He identified these as her age, chronic pre-existing right lateral elbow calcific tendinitis, right elbow arthritis, a long smoking history, and relatively manually intensive hobbies including golf, motorcycle riding and volleyball performed on a regular basis over a period of many years. Lastly, Dr. Sudekum was of the opinion that if petitioner did suffer from pre-existing chronic right lateral epicondylitis, it is possibly likely that she may have experienced some acute/sharp pain in the right lateral elbow if and when she struck her elbow while mopping the shower stall, and this incident may have served as an aggravating factor in the exacerbation of her subjective symptoms associated with a pre-existing pathology. He further opined that the 8/25/15 injury did not cause and/or result in any significant progression of the pathology of lateral epicondylitis, calcific tendinitis, or elbow arthritis. Dr. Sudekum was also of the opinion that it is possible that petitioner's condition may have been aggravated by her regular employment activities as a housekeeper.

Petitioner followed up with Dr. Oakey's office on 4/4/16, 5/2/16, 6/16/16, 7/18/16, 8/22/16, and 10/3/16. During this period Dr. Oakey was continuing to wait for authorization from Worker's Compensation for petitioner's surgery. During this period Dr. Oakey continued petitioner's work restrictions.

On 10/20/16 petitioner underwent a right lateral epicondylar debridement and repair performed by Dr. Jerome Oakey. Petitioner's postoperative diagnosis was right lateral epicondylitis. Petitioner followed up postoperatively at Dr. Oakey's office on 10/31/16. Dr. Oakey continued petitioner off work. On 11/16/16 petitioner began another course of occupational therapy.

On 11/18/16 Dr. Oakey drafted a letter to petitioner's attorney Jean Swee. Dr. Oakey noted that he began treating petitioner for her right lateral epicondylitis on 11/9/15, and at that point petitioner related an injury in which she struck her right elbow on a shower stall at work around 8/25/15, and since that time has had pain and swelling at the lateral aspect of the elbow. He was of the opinion that an MRI was ordered that showed lateral epicondylitis. He noted that the IME suggested that petitioner had calcific tendinitis, and the findings on the x-ray appeared chronic. Dr. Oakey was of the opinion that it was important to note that petitioner had no symptoms that she related to him prior to her injury on 8/25/15, and that when petitioner saw Dr. Chow on 8/20/15 she had swelling, pain, and bruising at the right lateral epicondyle, consistent with an acute injury. Dr. Oakey noted that he did not agree with Dr. Sudekum's opinion that lateral epicondylitis is a chronic condition that occurs over a long period of time and is not caused by a one-time acute event. Dr. Oakey stated that he has seen a number of instances of patients developing acute lateral epicondylitis following a traumatic event such as petitioner's. Dr. Oakey therefore noted that he felt that the injury petitioner described was causally connected to her right lateral epicondylitis. Dr. Oakey was of the opinion that the calcifications that are seen in the original x-ray, and were highlighted in the IME as evidence of a chronic process, were asymptomatic prior to the injury on 8/25/15, which is something Dr. Oakey sees very commonly on elbow x-rays for other pathology.

On 11/28/16 petitioner followed up with Dr. Oakey. She stated that she was doing well overall and had minimal soreness with activity and range of motion. She stated that her function was continuing to improve. Dr. Oakey released petitioner to work on 12/5/16 with no more than 10 pounds use of the right arm. He also instructed her to wear her brace for comfort.

On 12/2/16 petitioner was discharged from occupational therapy. Petitioner had either met her goals or was in the process of meeting her goals when therapy ended. On 12/28/16 petitioner returned to Dr. Oakey. Dr. Oakey restricted petitioner from no more than 25 pound use of the right upper extremity.

On 1/25/17 petitioner last followed up with Dr. Oakey. Petitioner reported no pain and only a mild issue with gripping and lifting. She noted that she had not experienced any aggravations with his increasing of her lifting restrictions. Dr. Oakey was of the opinion that petitioner was doing well. He released her to full duty and instructed her to return back in six weeks for an anticipated MMI. Dr. Oakey released petitioner to return to work on 1/25/17 without any restrictions.

On 3/9/17 petitioner last followed up with Dr. Oakey. She reported that she was doing great, and had no pain or aggravating factors. Dr. Oakey noted that her range of motion was intact, she had no limitations, and there was no associated numbness or tingling. Dr. Oakey was of the opinion that he did not feel petitioner

would need any further medical care. He released her on an as needed basis to full duty work without restrictions.

On 6/20/17 the evidence deposition of Dr. Sudekum, certified in plastic reconstructive surgery and surgery of the upper extremity, was taken on behalf of the respondent. He opined that it is highly unusual that someone would develop lateral epicondylitis from an acute injury unless it was quite a severe trauma. He further opined that if someone experiences a real significant direct, forceful impact to the lateral epicondyle region, that can cause a tear. He stated that this would normally be associated with fairly significant soft tissue swelling, injury, laceration, high-impact trauma, or high-energy trauma. He did not think a bump against the door jam would do that. Dr. Sudekum opined that petitioner had a pre-existing condition of lateral epicondylitis on 8/25/15 that resulted in increased subjective complaints after she bumped her elbow against the door stall. He again opined that that the injury on 8/25/15 did not cause or result in any significant progression of the pathology of her lateral epicondylitis, her calcific tendinitis, or elbow arthritis. He did not believe the course of her condition was changed pathologically or clinically by the injury on 8/25/15.

On cross-examination, Dr. Sudekum was of the opinion that evidence of an acute trauma could include acute swelling, red and purple bruising, and limited range of motion in the arm. Dr. Sudekum noted that petitioner told him that she did not have any pain prior to the injury on 8/25/15, yet continued to have pain after that date.

On 7/2/17 the deposition of Dr. Oakey was taken on behalf of petitioner. Dr. Oakey opined that his diagnosis as it related to petitioner's 8/25/15 injury was right lateral epidural condylitis, or tennis elbow. Dr. Oakey further opined that the accident on 8/25/15 contributed to her cause to need the medical care that he provided, including the surgery. He opined that the work injury as described by petitioner is causally related to the genesis of her tennis elbow, and need for surgery. Dr. Oakey was of the opinion that petitioner had no symptoms before 8/25/15, then sustained a traumatic injury, and then developed the symptoms of lateral epicondylitis. Dr. Oakey opined that he disagreed with Dr. Sudekum's opinion that petitioner's right elbow condition was pre-existing, and that it is possible it was due to home activities or even work activities, since petitioner never related to him any symptoms prior to the injury on 8/25/15.

On cross-examination Dr. Oakey opined that it is not uncommon for no soft tissue abnormalities or joint effusion to be seen on the x-ray that was performed on the date of injury. Dr. Oakey opined that the findings on the MRI did not show any other etiology other than lateral epicondylitis. Dr. Oakey was of the opinion that it is not uncommon for the manifestation of the lateral epicondylitis to go from an asymptomatic interval to having a normal cascade of symptomatology after striking your elbow. Dr. Oakey noted that when he performed the

surgery there was no evidence of calcific tendinitis in petitioner's right elbow, which is contrary to what Dr. Sudekum opined. He further opined that calcifications are rarely symptomatic. Dr. Oakey opined that there is no significance to petitioner's symptoms that the calcifications on the x-ray were located next to or near the lateral epicondyle.

Petitioner testified that she has remained in the same position with respondent since the injury. She further testified that she has gotten a pay raise since the injury to the top pay. Petitioner makes $19.60 an hour, and works about 37.5 hours a week. Petitioner is right hand dominant.

Petitioner testified that she notices some aching and soreness after scrubbing, vacuuming, and mopping. Petitioner testified that when she is not working it is better. Petitioner takes Aleve about 3-4 days a week.

Respondent confronted petitioner with a photo on her Facebook where she was holding a shot gun on 10/20/15. She stated that the photo was staged and that she never shot that gun. Petitioner testified that she did target shooting for 5 years. Petitioner testified that she did not shoot on 10/20/15, and does not shoot now. Petitioner testified she used to play golf most weekends and played volleyball weekly before the injury for about 5 years. She also stated that she used to drive a motorcycle but had not done that in four years. She testified that she does still ride with her husband. She also stated that she golfed a couple of times this past summer. Petitioner has smoked 1/2 pack of cigarettes a day for the past 20 years.

Petitioner testified that she is currently able to complete her job duties. She also testified that she has not had any treatment since she was released by Dr. Oakey.

Petitioner testified that she has not received any temporary total disability benefits from respondent for the time she was off work.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner, is alleging she sustained either a specific trauma injury (15 WC 38106) or repetitive work injury (16 WC 31065), that arose out of and in the course of her employment on 8/25/15. Respondent did not object to petitioner pursuing both theories for the same date of accident.

On 8/25/15 while in the shower mopping the shower floor with a scrub brush that was attached to a pole, petitioner injured her right elbow, when she turned and struck her right elbow with some force against the shower stall. Petitioner experienced immediate pain in her right elbow, as well as swelling and bruising about the right elbow. She testified that it hurt to do anything with her arm. Petitioner reported the injury

immediately after it occurred. Respondent did not offer any rebuttal evidence to support a finding that petitioner did not strike her right elbow against the shower stall while cleaning a dorm bathroom.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner sustained a specific accidental injury to her right elbow that arose out of and in the course of her employment by respondent on 8/25/15. Having found the petitioner sustained a specific accidental injury to her right elbow that arose out of and in the course of her employment by respondent on 8/25/15, the arbitrator finds the issue of petitioner sustaining an accidental injury to her right elbow due to repetitive work activities on 8/25/15 a moot issue.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Following the injury to her right elbow on 8/25/15 petitioner first sought treatment with Dr. Chow on the referral of the respondent. Petitioner provided a consistent history of the accident. She complained of pain with movement of her right elbow. An examination revealed bruising and swelling even though the x-ray showed no abnormality of the soft tissue or effusion of the elbow joint. She was initially assessed with a right elbow contusion. Petitioner continued to follow-up with Dr. Chow and continued with tenderness about the lateral epicondyle, and swelling and bruising around the lateral epicondyle area. She also had tenderness with forced extension. Petitioner was provided with prednisone, a sleeve, and physical therapy. When petitioner was discharged from physical therapy she still had a lot of elbow pain. She also had a small dark red discoloration over her right elbow where the iontophoresis treatments were performed. The therapist noted that petitioner had made little or no progress.

Petitioner was then referred to Dr. Oakey. He assessed right lateral elbow pain that he believed represented lateral epicondylitis that began with a traumatic event. An MRI of the right elbow revealed a partial tear of the common extensor tendon with no full thickness tear or tendon retraction. Dr. Oakey performed a steroid injection into petitioner's right lateral condyle. Petitioner had some temporary relief. She also underwent another course of physical therapy. Dr. Oakey assessed soft tissue loss from steroids that were administered in physical therapy. When petitioner failed conservative treatment Dr. Oakey recommended a right lateral epicondylar debridement and repair that petitioner ultimately underwent on 10/20/16, despite respondent not authorizing the treatment based on the opinions of Dr. Sudekum.

Dr. Sudekum's opinions often contradicted each other. At first, Dr. Sudekum was of the opinion that based on petitioner's accident history that her right lateral epicondylitis developed acutely as a result of the injury on 8/25/15. He was further of the opinion that petitioner had no preexisting condition affecting the right elbow, specifically right lateral epicondylitis, prior to 8/25/15. But then stated that he believed petitioner had chronic calcific tendinitis and lateral epicondylitis that preexisted the injury. Dr. Sudekum was also of the

opinion that petitioner only had a relatively minor traumatic injury or contusion based on the fact that x-ray on the date of injury revealed no soft tissue abnormality or elbow joint effusion. Dr. Sudekum also believed petitioner demonstrated symptom magnification. Although Dr. Sudekum was of the opinion that petitioner had some pre-existing, non-work related risk factors and/or comorbidities that could predispose her to develop lateral epicondylitis in her right elbow regardless of her work activities or injury, the arbitrator finds there is no credible evidence to support this claim, and finds this opinion by Dr. Sudekum is purely speculative. Dr. Sudekum then went on to state that if petitioner had preexisting chronic right lateral epicondylitis, it is possibly likely that she may have experienced some acute/sharp pain in the right lateral elbow if and when she struck her elbow while mopping the shower stall, and that incident would have served as an aggravating factor in the exacerbation of her subjective symptoms associated with a pre-existing pathology. The arbitrator finds this opinion clearly supportive of a finding that if petitioner did have a pre-existing right elbow condition, the injury on 8/25/15 clearly exacerbated and aggravated that condition, thus finding the petitioner's current condition of ill-being is causally related to the injury on 8/25/15. Although Dr. Sudekum then went on to opine that the 8/25/15 injury did not cause and/or result in any significant progression of pathology of the lateral epicondylitis, calcific tendinitis and elbow arthritis, based on the credible evidence, the arbitrator does not give much weight to this opinion given the fact that there is no credible evidence to support a finding that these conditions preexisted the injury, and the conditions, if present, did not result in any significant progression of pathology. Although Dr. Sudekum also went on to state that it is also possible that petitioner's condition may have been aggravated by her regular employment activities as a housekeeper, he presented no credible evidence to support this claim.

Dr. Oakey, petitioner's orthopedic surgeon, opined that petitioner's current condition of ill-being as it relates to her right elbow is casually related to the injury on 8/25/15 when she struck her right elbow on a shower stall at work and had pain and swelling at the lateral aspect of the elbow following the incident. Dr. Oakey was of the opinion that it is important to note that petitioner had no symptoms in her right elbow prior to 8/25/15, and that immediately afterwards she had swelling, pain and bruising in her right elbow consistent with an acute injury. Dr. Oakey noted that he has seen a number of instances of patients developing acute lateral epicondylitis following a traumatic event such as petitioner's. Dr. Oakey further opined that the calcifications seen on the x-ray and that were highlighted by Dr. Sudekum as evidence of a chronic process, were asymptomatic prior to the injury.

In his deposition Dr. Sudekum was of the opinion that if someone experiences a real significant direct, forceful impact to the lateral epicondyle region, that can cause a tear. Given the documented swelling, bruising

and pain immediately following the injury, as well as petitioner's unrebutted testimony that she struck her right elbow with force against the shower stall, the arbitrator finds petitioner's injury could cause a tear in the right elbow.

In his deposition Dr. Oakey opined that his diagnosis as it related to petitioner's 8/25/15 injury was right lateral epidural condylitis, or tennis elbow, and that the accident on 8/25/15 contributed to her cause to need the medical care that he provided, including the surgery. He further opined that the work injury as described by petitioner is causally related to the genesis of her tennis elbow, and need for surgery. Dr. Oakey was of the opinion that petitioner had no symptoms before 8/25/15, then sustained a traumatic injury, and then developed the symptoms of lateral epicondylitis. Dr. Oakey opined that he disagreed with Dr. Sudekum's opinion that petitioner's right elbow condition was pre-existing, and that it is possible it was due to home activities or even work activities, since petitioner never related to him any symptoms prior to the injury on 8/25/15.

On cross-examination Dr. Oakey opined that it is not uncommon for no soft tissue abnormalities or joint effusion to be seen on the x-ray that was performed on the date of injury. Dr. Oakey further opined that the findings on the MRI did not show any other etiology other than lateral epicondylitis. Dr. Oakey was of the opinion that it is not uncommon for the manifestation of the lateral epicondylitis to go from an asymptomatic interval to having a normal cascade of symptomatology after striking your elbow. He also noted that when he performed the surgery on petitioner's elbow there was no evidence of calcific tendinitis in petitioner's right elbow, which is contrary to what Dr. Sudekum opined. He was also of the opinion that calcifications are rarely symptomatic.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Oakey are far more persuasive than those of Dr. Sudekum, especially given the fact that many of Dr. Sudekum's opinions contradicted each other, and were often speculative at best. The arbitrator adopts the opinions of Dr. Oakey and finds the petitioner's current condition of ill-being as it relates to her right elbow, is causally related to the injury she sustained to her right elbow on 8/25/15. The arbitrator finds it significant that petitioner was totally asymptomatic prior to the injury on 8/25/15; that petitioner forcefully struck her right elbow on the shower stall; that petitioner had immediate swelling, bruising and pain about her right elbow immediately after the injury; that petitioner's complaints continued until she underwent a right lateral epicondylar debridement and repair performed by Dr. Oakey; and, that petitioner's condition improved after the surgery.

J. WERE 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 petitioner sustained an accidental injury to her right elbow that arose out of and in the course of her employment by respondent on 8/25/15, and that petitioner's current condition of ill-being as it relates to her right elbow is causally related to the injury she sustained on 8/25/15, the arbitrator finds all treatment petitioner received for her right elbow from 8/25/15 to 3/9/17 was reasonable and necessary to cure or relieve petitioner from the effects of her injury on 8/25/15.

Based on the above, as well as the credible evidence, the arbitrator finds the respondent shall pay reasonable and necessary medical services related to petitioner's right elbow from 8/25/15 through 3/9/17, as provided in Section 8(a) 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.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner claims she was temporarily totally disabled from 11/16/15 through 12/5/16, a period of 54-5/7 weeks. The respondent denies liability for any temporary total disability benefits, and claims that if accident and causal connection are found that the period of temporary total disability would only be from 11/6/15 through 11/2/16. Having found petitioner sustained an accidental injury to her right elbow that arose out of and in the course of her employment by respondent on 8/25/15, that petitioner's current condition of ill-being as it relates to her right elbow is causally related to the injury she sustained on 8/25/15, and that Dr. Oakey authorized petitioner off work from 11/16/15 through 12/5/16, the arbitrator finds the petitioner was temporarily totally disabled from 11/16/15 through 12/5/16, a period of 54-5/7 weeks.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

As a result of the injury on 8/25/15 petitioner sustained an injury to her right elbow. After failing conservative treatment, the petitioner ultimately underwent a right lateral epicondylar debridement and repair. Petitioner was ultimately released to full duty work.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a building service worker at the time of the accident and that she was able to return to work to her prior capacity following her treatment for said injury. The Arbitrator notes that following the injury petitioner worked light duty, was taken off work following the surgery, then again worked light duty, before ultimately being released to full duty work by Dr. Oakey on 1/25/17. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 42 years old at the time of the accident. Because petitioner was ultimately released to full duty work, and continued in that capacity as of trial, the arbitrator gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that petitioner returned to her regular duty job and has remained working in that capacity. Petitioner has also received a raise that puts her at top pay for her job. Because of this, 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 petitioner last treated with Dr. Oakey on 3/9/17. At that time petitioner reported that she was doing great and had no pain or aggravating factors. Dr. Oakey noted that her range of motion was intact, she had no limitations, and there was no associated numbness or tingling. Because of this 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 12.5% loss of use of her right arm pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ryan Kmieciak,

Petitioner,

vs.

NO: 14 WC 10769

18IWCC0370

Reynolds Consumer Products Inc.,
d/b/a Pactiv Corp.,

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 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.

Initially, the Commission notes that prior to the arbitration hearing, the parties consolidated this case with a subsequent case. Case number 14 WC 10935 involves a subsequent injury to Petitioner's left hand that occurred on March 1, 2014. While the parties addressed both cases during the arbitration hearing, the Arbitrator issued separate Decisions for each case. The Commission addresses the issues Respondent raised on review relating to the companion case in a separate Decision.

On February 12, 2013, Petitioner hit his left hand on a metal pole while performing his work duties. Dr. Gordon, Petitioner's treating physician, diagnosed Petitioner with left de Quervain's tenosynovitis. Petitioner underwent a corticosteroid injection into the left first dorsal compartment in April 2013. The injection resolved Petitioner's de Quervain's symptoms; however, Petitioner continued to complain of symptoms in the left thumb metacarpal between the MCP and CMC joints. A July 2013 MRI of Petitioner's left hand revealed mild osteoarthritis with no focal abnormality found in the location Petitioner complained of pain. An MRI of the left wrist revealed tenosynovitis of the second and fifth extensors with no abnormality found in the areas where Petitioner complained of pain. Dr. Gordon placed Petitioner at MMI on July 31, 2013. Petitioner did not lose any time from work due to this work accident. Petitioner testified that he continued to experience chronic symptoms such as limited mobility, weakness, sharp and stabbing pain, and occasional tingling following his release to return to work. Despite these ongoing symptoms,

Petitioner sought no additional treatment relating to this work accident and continued to work without restriction until he suffered the subsequent injury to his left hand on March 1, 2014.

The Arbitrator found Petitioner failed to prove that his current condition of ill-being is causally related to this February 2013 work accident because Petitioner's subsequent March 2014 accident severed the chain of causation. After evaluating the relevant factors pursuant to Section 8.1(b) of the Act, the Arbitrator determined Petitioner suffered a 5% loss of use of his left hand pursuant to Section 8(e). The Commission finds the Arbitrator's award of permanent partial disability was in error. The Commission notes that only eight months elapsed between July 31, 2013, the date of MMI, and March 1, 2014, the date of Petitioner's subsequent work injury to his left hand. Following the March 1, 2014, work accident, Petitioner complained of left hand, wrist, and thumb symptoms almost identical to his complaints following this February 2013 accident. In fact, Petitioner's doctor also diagnosed de Quervain's tenosynovitis following the March 2014 injury. Petitioner eventually underwent a release of the left wrist de Quervain's tenosynovitis on February 6, 2015. In October 2015 Petitioner's doctor also prescribed significant permanent restrictions due to the March 2014 injury. Clearly, the March 2014 left hand injury was much more significant than the initial February 2013 injury.

Given the limited amount of time between the date Petitioner reached MMI and the March 1, 2014, injury as well as the severity of the March 2014 injury, the Commission finds Petitioner did not sustain any permanent partial disability due to the February 2013 work accident. The Commission's denial of an award pursuant to Section 8(e) follows precedent established by the appellate court. In *Baumgardner v. Ill. Workers' Comp. Comm'n*, the court considered a case involving a claimant who suffered two distinct right knee injuries in separate work accidents, much like Petitioner in this case. 409 Ill. App. 3d 274 (2011). The Commission declined to award permanent partial disability in each case; instead, the Commission issued a single permanent partial disability award reflecting the claimant's overall condition of ill-being at the arbitration hearing. The appellate court affirmed the Commission's decision to enter a single award stating, "Because the claimant suffered multiple injuries to the same body part as a result of successive accidents and those claims were tried together, the Commission properly evaluated the totality of the evidence as it related to the claimant's overall condition of ill-being at the time of the hearing and entered a single award that encompassed the full extent of the disability..." *Id.* at 280. Because Petitioner suffered a much more severe injury to the same body parts less than a year after this accident, it is not possible for the Commission to separate which, if any, of Petitioner's current complaints are solely related to this work accident.

After carefully considering the totality of the evidence, the Commission finds Petitioner did not meet his burden of proving that he suffered any permanent disability due to this initial work injury. Thus, the Commission vacates the Arbitrator's award of 5% loss of use of the left hand.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 19, 2017, is modified as stated herein.

18IWCC0370

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,451.75. The party commencing the 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 12 2018

o: 3/20/18
TJT/jds
51

Michael J. Brennan

Kevin W. Lamborn

DISSENT

I respectfully dissent from the opinion of the majority and would affirm and adopt the Arbitrator's Decision. After considering the totality of the evidence, I believe Petitioner met his burden of proving by a preponderance of the evidence that he sustained permanent impairment to his left hand due to the February 12, 2013, work accident.

Petitioner sustained an injury to his left hand that Dr. Gordon diagnosed as de Quervain's tenosynovitis. Petitioner underwent conservative treatment and did not lose any time from work. On July 31, 2013, Dr. Gordon placed Petitioner at MMI. Petitioner complained of ongoing symptoms even during that final visit. Dr. Gordon's nurse practitioner even gave Petitioner Theraputty to use due to his ongoing complaints. Petitioner continued to work full duty in his original position as a machine operator until he suffered a subsequent accident to his left hand on March 1, 2014. Although Petitioner undoubtedly sustained a more serious injury on March 1, 2014, there is sufficient evidence to determine the amount of permanent disability Petitioner incurred due to this February 2013 left hand injury. Even after achieving MMI, Petitioner continued to experience significant symptoms. Petitioner's counsel specifically questioned Petitioner regarding his complaints from July 31, 2013, through March 1, 2014. In response, Petitioner testified that he experienced weakness in his left wrist, limited mobility, and occasional sharp stabbing pain and a tingling sensation in his left thumb and wrist during that period. (Tr. at 33, 60-61). Petitioner credibly testified that he experienced these lingering symptoms until the subsequent work accident.

The majority relies on *Baumgardner v. Ill. Workers' Comp. Comm'n* to support the denial of permanent partial disability. 409 Ill. App. 3d 274 (2011). However, this current case is distinguishable from *Baumgardner*. In *Baumgardner*, the Commission found the claimant failed to present sufficient evidence to support his condition of ill-being, or any part thereof, was due to the initial injury. The appellate court found the Commission's decision was not against the manifest weight of the evidence. Here, Petitioner specifically testified regarding the ongoing and significant symptoms he experienced up to the subsequent March 2014 injury to his left hand. Respondent presented no evidence to rebut Petitioner's testimony regarding his ongoing symptoms. Respondent also did not obtain an impairment rating in the eight months prior to Petitioner's March 2014 injury. After considering the evidence of permanent disability resulting from Petitioner's February 12, 2013, work accident, I believe the Arbitrator's award of 5% loss of use of the left hand is proper.

For the forgoing reasons, I would affirm and adopt the Arbitrator's Decision and find Petitioner suffered a 5% loss of use of the left hand due to the February 12, 2013, work accident.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KMIECIAK, RYAN
Employee/Petitioner

Case# **14WC010769**
14WC010935

REYNOLDS CONSUMER PRODUCTS INC D/B/A PACTIV CORPORATION
Employer/Respondent

18IWCC0370

On 1/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2934 BOSHARDY LAW OFFICE PC
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SPRINGFIELD, IL 62703

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2710 N KNOXVILLE AVE
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18IWCC0370

STATE OF ILLINOIS)
)
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

Ryan Kmieciak
Employee/Petitioner

Case # 14 WC 10769

v.

Consolidated w/14 WC 10935

Reynolds Consumer Products, Inc. d/b/a Pactiv Corporation
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Nancy Lindsay, Arbitrator of the Commission, in the city of Springfield, on November 18, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On **February 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 $ **29,172.00**; the average weekly wage was $ **545.00**.

On the date of accident, Petitioner was **36** years of age, *married* with **1** dependent child.

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 for $**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** 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 Petitioner permanent partial disability benefits of $ **327.00**/week for **10.25** weeks, because the injuries sustained caused **5** % loss of the use of the left hand as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **February 12, 2013** through **November 18, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services in the amount of $ **318.45**, subject to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of arbitrator

January 16, 2017
Date

JAN 19 2017

Ryan Kmieciak vs. Reynold's Consumer Products d/b/a Pactiv Corporation, 14 WC 10769

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner was involved in an undisputed work accident on February 12, 2013. (AX 1) At that time Petitioner struck his left hand on a metal pole. Petitioner sought no immediate medial care.

Petitioner sought treatment at Passavant Area Hospital on March 2, 2013. He informed the emergency room staff of the accident, noting that two weeks before he had struck his left hand on a metal pole and was experiencing pain shooting up his forearm. (PX 7) Petitioner's pain drawing noted tenderness in his left thumb on both the top and bottom. (PX 7) X-rays of Petitioner's left hand and thumb were negative. (PX 7) Petitioner was examined, diagnosed with a contusion, placed in a thumb spica splint, removed from work for two days and referred to Dr. Greene for follow-up care. (PX 7)

Petitioner was next seen by Nurse Practitioner Jane Kamp at Midwest Occupational Health Associates (MOHA) on March 4, 2013 regarding his left thumb pain. Petitioner advised N.P. Kamp of the accident wherein he hit his left thumb on a metal pole. Petitioner reported that he continued working thereafter and that his regular job was that of a carousel operator; however, if another worker was sick or a fill-in was needed he would help out (but this was rarely). Petitioner further informed Ms. Kamp that he was loading a machine with cardboard boxes which required him to grab 30-40 boxes at a time and put them in the machine. He would use his left hand and did so 56 times in one hour which did not include doing drawer tape and other tasks. Petitioner remarked that he had counted the repetitions and believed it "had a high incidence for injury potential." Petitioner reported difficulty squeezing with his left hand and informed Ms. Kamp of his visit to the ER Department on Saturday[1] at which time he was given a brace. On examination Ms. Kamp noted Petitioner's left wrist had mild decreased range of motion upon flexion and extension. He was "excessively hypersensitive" to light touch of his left wrist and left thumb and hand. She could not appreciate any edema or erythema in his left hand, wrist or thumb. He moved his thumb and fingers very cautiously. Petitioner was diagnosed with left thumb pain and prescribed Ibuprofen three times a day along with Extra Strength Tylenol. He was to also use ice on his left hand and thumb as needed. He was cleared for work but told to use caution at work

and "not utilize his support [brace] more than 6 hours per work shift and to not utilize it in his nonworking and sleeping hours." Petitioner's pain drawing indicated Petitioner had stabbing pain on the top of his left hand and thumb up into his forearm. Petitioner rated his pain as a six out of ten. (PX 3)

Petitioner was then seen by Dr. Robert Gordon at MOHA on March 8, 2013 where it was noted that Petitioner had increased pain in the region of his dorsal compartment and that his work activities were causing his symptoms to continue and worsen. (PX 3) On examination Dr. Gordon noted a positive Finkelstein's test and he diagnosed Petitioner with DeQuervain's Syndrome and prescribed Prednisone. He did not restrict Petitioner's work activities although he advised Petitioner to "use caution with his left upper extremity." Dr. Gordon's notes indicate that he also explained this to Mark Strubble, Respondent's safety director. After the course of Prednisone, Petitioner was to go back on Ibuprofen. He was further told to check in with nursing routinely. Dr. Gordon wished to see him again in two weeks, further noting that if there no improvement at that time, consideration would be given to an injection. (PX 3)

As instructed, Petitioner followed up with Dr. Gordon on March 20, 2013. Petitioner reported some improvement in his left thumb but continued pain with performing certain work activities and at the region of the first dorsal compartment near the thumb. Petitioner was told to continue with the Ibuprofen and Extra Strength Tylenol, along with ice and heat as needed. He, again, was instructed to utilize caution while performing his regular work. (PX 3)

Petitioner returned to Dr. Gordon on April 12, 2013 noting that he continued to be symptomatic. Petitioner had tenderness in the region of the first dorsal compartment and a positive Finkelstein's. Dr. Gordon injected Petitioner's left first dorsal compartment and released Petitioner to return to work without restrictions but, again, with "caution." (PX 3)

On May 10, 2013 Petitioner returned to Dr. Gordon reporting that he was 80 to 85% better since undergoing the injection. However, his primary pain was noted to be in the thumb MCP joint region and in the ulnar aspect of the thumb MCP joint. He denied any gross instability sensation or other numbness or tingling in the left hand. On examination Petitioner lacked any gross tenderness in the first dorsal compartment. He did have mild tenderness of the left thumb in the region of the ulna collateral ligament but no edema. Petitioner had excellent pinch grip strength and lacked any laxity in comparison to the right. Dr. Gordon's impression was that of

[1] 3/2/13

left DeQuervain's Syndrome by history although Petitioner was doing much better after the injection. Petitioner remained symptomatic in the region of the left thumb MCP joint ulnarly. He was prescribed Mobic one tablet per day and, again, told to use caution at work. If he failed to improve when re-examined in four weeks, an MRI would be considered. (PX 3)

Petitioner then sought care from Dr. Randall Voigts on May 22, 2013 to establish care. Petitioner advised Dr. Voigts of the work accident in February and his continued wrist pain but he was not specifically seeking care for that problem as it was being treated by Dr. Gordon. Nevertheless, Dr. Voigts noted Petitioner had left hand pain, at the base of the thumb on the left hand. Dr. Voigts noted Petitioner had a positive Finkelstein's test and he recommended that Petitioner "ask about seeing an orthopedist". (PX 11)

Petitioner returned to Dr. Gordon on June 7, 2013 noting continued pain in the left thumb with the majority of his symptoms located in the left thumb metacarpal between the MCP to CMC joints. Petitioner also reported the Mobic wasn't helping. On exam, he lacked any tenderness in the region of the first dorsal compartment or edema. Dr. Gordon noted a negative Finkelstein's test. Petitioner had full range of motion at the CMC joint and MCP joint of the left thumb. Petitioner had tenderness in the region of the first metacarpal but no edema. There were no issues with thumb opposition or neurovascular abnormalities. Petitioner's diagnoses remained unchanged. Dr. Gordon recommended an MRI of the left hand and wrist due to left radial wrist pain, Voltaren rather than Mobic, and ongoing caution with work activities. (PX 3)

Petitioner underwent the MRI on July 18, 2013. The MRI was positive for mild osteoarthritis of the carpometacarpal and metacarpophalangeal joints. (PX 4) There was also mild tenosynovitis of the second and first extensors in the left wrist. (PX 3, 4) In a chart note dated July 24, 2013 Dr. Gordon discussed the results with Petitioner, noting the radiologist who read them was a radiological musculoskeletal specialist. He did not recommend any further diagnostic studies or therapeutic interventions but noted he would be recommending that Petitioner use Theraputty and engage in home exercises. (PX 3)

Petitioner returned to see Dr. Gordon on July 31, 2013 noting continued pain and tenderness of the first metacarpal. On exam the doctor noted tenderness in the first dorsal compartment and in the region of the left first metacarpal. No edema in either region was noted and he had full range of motion in all joints of the left thumb and wrist. Dr. Gordon noted his discussion with Petitioner stating that the MRIs did not reveal any abnormality in the areas where Petitioner

complained of pain. Petitioner was told his symptoms would be self-limiting and he was instructed in the use of Theraputty. Petitioner was discharged from care. (PX 3)

Petitioner underwent no further medical care between July 31, 2013 and March 7, 2104.

On March 7, 2014 Petitioner again presented to Dr. Gordon. As part of the exam Petitioner completed a questionnaire in which he noted he had a current condition of arthritis in his left two fingers and thumb from a previous injury. At that time Petitioner reported that on/about March 1, 2014 he was operating an electric hand jack and had to stop suddenly resulting in his left hand slipping off the handlebar and his left wrist and thumb being twisted. Since then Petitioner had noticed pain. Petitioner had not undergone any x-rays and he reported that he was currently on Prednisone for plantar fasciitis which wasn't really helping. Petitioner, on exam, had diffuse swelling of his left wrist and hand with exquisite tenderness over the first dorsal compartment of his left wrist and his dorsal wrist, generally. He also had tenderness of his left dorsal hand but not as much as in the wrist. Petitioner was unable to make a handgrip on the left due to pain and swelling. A pain drawing was completed by Petitioner and Petitioner described his symptoms as very intense (ie. unable to perform daily tasks/unable to perform job). Dr. Gordon's impression was left wrist/hand pain with edema and he ordered an x-ray of both Petitioner's hand and wrist. He also recommended Tylenol and wished to see him later that day after completion of the x-rays. (PX 3)

X-rays were performed at the Springfield Clinic on March 7, 2014 due to Petitioner's "jamming of his hand and wrist backwards." They were read as negative. (PX 5) Given Petitioner's complaints and notable swelling, an MRI was recommended at that time. In the interim Petitioner was allowed to perform full duty work "with caution." (PX 3)

Petitioner stopped working for Respondent on March 11, 2014. (RX 6, p. 1, para. 2)

The MRI was performed at the Springfield Clinic on March 18, 2014 revealing osteoarthritis of the left metacarpophalangeal joint and the trapezio-scaphoid. (PX 3, 5)

Petitioner's employment with Respondent ended on/about March 19, 2014. (RX 6, p. 1, para. 2)

On March 24, 2014 Petitioner returned to Dr. Gordon who noted continued symptoms in Petitioner's left upper extremity, especially in the area of the dorsal thumb region, radial wrist region, and his distal radial forearm region. Petitioner was really uncertain if he was improving or not and was unable to tolerate the Naprosyn and, therefore, wasn't utilizing any medication at

the present. He was also using a left thumb spica that had previously been issued to him by Dr. Gordon. Petitioner also reported that he was no longer working for Respondent. On examination Petitioner had tenderness to very light palpation of his left dorsal thumb region, radial wrist region, and distal radial forearm region. Dr. Gordon noted that Petitioner had significant withdrawal with just barely touching his skin and difficulty making a fist. Petitioner's edema was notably improved and he was able to move each of the joints of his thumb. Dr. Gordon's impression was left upper extremity pain, most notably of the radial forearm, wrist and dorsal thumb region. Overall, Petitioner's clinical exam was improved from his last exam. Dr. Gordon described Petitioner's examination of that date as "notably nonphysiologic" and based upon Petitioner's reported mechanism of injury the doctor could not conclude that Petitioner's current symptomology was related to a mechanical disorder secondary to the workplace as has been described to him within a reasonable degree of medical certainty. He recommended Relafen, continued use of the thumb Spica case, Theraputty, and follow-up in two weeks, or sooner, if needed. Petitioner was cleared to perform all job functions associated with his regular job duties albeit "with caution." (PX 3)

Petitioner signed his Application for Adjustment of Claim in case # 14 WC 10769 on March 24, 2014 alleging a left hand/thumb injury on February 12, 2013. (PX 1)

Petitioner signed his Application for Adjustment of Claim in case # 14 WC 10935 on March 24, 2014 alleging a left hand/thumb injury on March 1, 2014. (PX 1)

On April 7, 2014 Dr. Gordon re-examined Petitioner who reported continued pain, inability to make a fist, and a pulling sensation when flexing his thumb. He did not feel like he was improving. (PX 3) On examination Dr. Gordon noted slight edema in the left wrist and thumb, tenderness to touch in the left dorsal and thumb area, and a hypersensitivity to light touch. Dr. Gordon again prescribed Prednisone and told Petitioner to use his thumb Spica splint at bedtime. (PX 3)

On April 14, 2014 Petitioner returned to Dr. Gordon reporting extensive swelling of his left wrist and hand for the previous two nights without any other incident. Dr. Gordon wrote, " I had been treating him for a reported work related incident with regard to his left upper extremity. I did discuss with him I can't explain why he would have such symptomatology of his left upper extremity at this point due to his reported work-related incident, especially given his reported mechanism of injury." Dr. Gordon examined Petitioner's left hand and wrist noting tenderness

to palpation, diminished range of motion of the wrist in all planes, edema of the left hand. With Finkelstein's maneuver Dr. Gordon was unable to accurately assess for it as Petitioner had symptomatology just with the initiation of the maneuver. Dr. Gordon further noted that, when asked, Petitioner could not make a fist but when "observed" he could. Dr. Gordon noted no coolness or dystrophic changes of the left upper extremity and excellent radial pulse at the wrist. Dr. Gordon diagnosed Petitioner with left wrist and hand symptoms of "unknown etiology". Dr. Gordon discussed sending Petitioner to an "upper extremity specialist" (Dr. Wottowa) but did not restrict Petitioner's work activity. Petitioner was advised to use over-the-counter Ibuprofen or Naproxen as needed. (PX 3)

A Chart Note contained within Dr. Gordon's records and dated April 15, 2014 noted that Michele Frye had contacted Dr. Gordon's office advising that Petitioner's "work comp claim" had been denied and, therefore, the referral to Dr. Wottowa was also denied. A letter from the "TPA" was being sent to Petitioner to advise him of the denial. (PX 3)

On April 23, 2014 Petitioner sought further treatment on his own from Dr. Mark Greatting. Petitioner, who was noted to be right hand dominant, described the work accident of March 1, 2014 to Dr. Greatting who further described it as a hyperextension injury to his left thumb and wrist. Petitioner also summarized the treatment he had up to that point, including Dr. Gordon's treatment. (PX 5) Dr. Greatting noted that Petitioner had been released from care approximately two weeks earlier and told to discontinue his splint and that he could return to work without restrictions but that he should use caution with his left wrist and hand. He was then subsequently released from his employment. Petitioner reported some tingling in the tip of his thumb but no other complaints of numbness or tingling. Dr. Greatting also reviewed Petitioner's x-rays and MRIs noting no abnormalities on the x-rays and some prior to his first visit on April 23, 2014. On examination, Dr. Greatting noted a hesitancy to flex and extend his left wrist as well as decreased flexion/extension of the wrist. Petitioner was tender to palpation around the left wrist/first dorsal compartment thenar area and carpometacarpal joint. Dr. Greatting noted the Petitioner tended to withdraw his hand from fairly light palpation and had "marked pain" with Finkelstein testing. Petitioner's most significantly tender area was the first dorsal compartment. Dr. Greatting also noted pain with palpation of the scaphotrapezial area and carpometacarpal joint with grind testing. Dr. Greatting diagnosed DeQuervain's tenosynovitis and suggested

Petitioner undergo physical therapy and an injection into the first dorsal compartment of his left wrist, which was performed. He was told to stay out of his splint as much as possible. (PX 5)

Petitioner presented to Passavant Hospital for physical therapy beginning on April 28, 2014. Petitioner reported debilitating left non-dominant hand pain. He described his job as a machine operator for Respondent; however, he had been terminated. (PX 8)

Petitioner cancelled his physical therapy appointment of May 5, 2014. (PX 8)

Petitioner returned to see Dr. Greatting on May 29, 2014. Dr. Greatting described Petitioner's pain from their initial visit as diffuse in nature but with some findings suggesting DeQuervain's Tenosynovitis. Petitioner reported that the injection caused increased pain for about three days and then no improvement. On exam the doctor noted some mild diffuse swelling of Petitioner's left hand but he could fully flex and extend his fingers. Petitioner was hesitant to move his thumb and was tender over the first dorsal compartment and significantly tender around the base of his thumb, the radial wrist and his volar wrist area. Petitioner had pain when attempting Finkelstein's test and some decreased flexion and extension of the wrist. Dr. Greatting's office notes record that a discussion was had between doctor and patient regarding the findings on exam which were not entirely consistent with DeQuervain's. Dr. Greatting believed Petitioner's pain related to his exam findings was not specifically localized to that area and appeared excessive for that diagnosis. Additionally, Petitioner's normal x-rays and MRI did not suggest any significant bony or ligamentous injury or problem to explain his pain. Dr. Greatting suspected a possible complex regional pain syndrome, ordered a 3 phase bone scan of the bilateral wrist and hands, and referred Petitioner to Dr. Koteswara Narla for evaluation and management of a possible complex regional pain syndrome. (PX 5)

Petitioner was discharged from therapy on July 8, 2014. The therapist noted that Petitioner was reportedly moaning and grunting when trying to move his thumb and wrist during active range of motion "apparently to indicate pain." This was the same when in the "Game ready." He was holding his hand in a guarded position. (PX 8)

The bone scan was not immediately authorized. Respondent sent Petitioner to Dr. James Williams for a Section 12 Exam. The exam took place on August 13, 2014. Dr. James Williams received a description of both work accidents and Petitioner's work activities and reviewed the medical records generated to that point. In his report Dr. Williams noted that Petitioner had not worked since March 11, 2014 and that he was currently unemployed having put in his two weeks

notice in February to leave and then receiving a call on March 19, 2014 advising him that he no longer had a job. At the time of the examination Petitioner was complaining of both left thumb and wrist symptoms. (RX 6)

On examination, Dr. Williams noted many findings similar to those noted by Dr. Greatting, including: extreme hypersensitivity to light touch over the left dorsal compartment of the left thumb; coldness over the left side; about one third decreased extension and flexion of the wrist when compared to the right wrist; tenderness over the left thumb and radial and dorsal aspects of the wrist; markedly positive Finklestein's test; pain with palpation of the scaphoid trapezial and carpometacarpal joint, and; decreased strength of the left thumb compared to the right.

Dr. Williams was of the opinion that Petitioner's "work accident" caused a complex regional pain syndrome, and aggravated a DeQuervain's tenosynovitis of the left wrist and hand. Dr. Williams noted that some of Petitioner's responses were exaggerated with inconsistency in grip strength testing, but he, nevertheless, felt that Petitioner's treatment to that point had been reasonable and Petitioner should be evaluated by Dr. Koteswara Narla for complex regional pain syndrome. Dr. Williams did not feel that Petitioner was at maximum medical improvement but he also felt Petitioner could work with restrictions. Dr. Williams noted that Petitioner had a pre-existing diagnosis of DeQuervain's from his February 12, 2013 accident but that Petitioner's current condition included both DeQuervain's Tenosynovitis and complex regional pain syndrome. (PX 6)

Petitioner underwent the three phase bone scan on September 5, 2014 which noted a mild degenerative pattern of radiotracer activity within the carpus on delayed phase according to the report. Nothing suggested RSD. (PX 5)

Petitioner was seen by Dr. Koteswara Narla on September 29, 2014. Petitioner provided Dr. Narla with a history of the work accident and his treatment to that point. Petitioner was wearing his splint to protect his thumb as he reported shooting pain from the base of his thumb and on the dorsal aspect of the thumb tip. He reported improvement in his previous swelling and thumb movement. Dr. Narla noted no color or temperature change, minimal swelling and pain of a six out of ten level. He also noted a very tiny degree of touch allodynia but no hyperalgesia or loss of sensation. (PX 5)

Dr. Narla was unable to conclude that Petitioner had complex regional pain syndrome but he was open to trying some pain medications including the neuropathic adjuvant medications or,

alternatively, Petitioner might wish to see a different pain center. They also discussed sympathetic blocks and use of Amitriptyline. Petitioner was encouraged to do passive and active thumb exercises. Alternatively, the doctor felt Petitioner might have had a soft tissue, ligamentous injury that had persisted for a longer period than normal. Dr. Narla prescribed Petitioner Neurontin, Amitriptyline, and Hydrocodone. (PX 5)

Petitioner was scheduled to return to Dr. Narla in six weeks but, instead, returned to Dr. Greatting on December 4, 2014. On that date Dr. Greatting and Petitioner discussed the bone scan and Dr. Narla's findings. Dr. Greatting examined Petitioner again and noted less sensitivity to light touch than when he first saw him, pain directly over the first dorsal compartment of the left wrist, and a markedly positive Finklestein's test. Dr. Greatting concluded that Petitioner's findings were consistent with DeQuervain's Tenosynovitis and he recommended a release of the left wrist first dorsal compartment although there was no guarantee this would resolve his pain. Dr. Greatting felt there was a good chance of significantly decreasing the Petitioner's pain. (PX 5)

Petitioner's attorney made a demand for TTD benefits through correspondence dated December 4, 2014. (PX 13)

Dr. Voights cleared Petitioner for surgery on January 22, 2015. (PX 11)

Petitioner underwent a left wrist DeQuervain's release on February 6, 2015. (PX 5; PX 9) As of February 18, 2015 Dr. Greatting released Petitioner to light duty work. Petitioner's attorney made a demand for TTD benefits or accommodation of his client's work restrictions through correspondence. (PX 13)As of March 19, 2015 Petitioner was markedly improved over his pre-operative course. Therapy was ordered. A full duty release in one month was anticipated. (PX 5)

Petitioner underwent physical therapy at Passavant Hospital between March 24, 2015 and July 22, 2015. (PX 12)

As of April 27, 2015 Dr. Greatting noted Petitioner was only reporting some intermittent pain. Petitioner felt his strength was significantly decreased but that therapy had helped. On exam Petitioner had good motion of his wrist and hand with no evidence of instability. On Finkelstein's testing he had mild pain. One more month of therapy was ordered, along with ongoing light duty. (PX 5)

Petitioner's attorney wrote to Respondent's attorney by letter dated April 27, 2015 requesting authorization for physical therapy and payment of TTD/accommodation. (PX 13)

Dr. Greatting re-examined Petitioner on June 3, 2015 noting some chronic pain and subjective complaints of weakness but that Petitioner was markedly improved from when he was first examined. His wrist flexion and extension was stable albeit some tenderness was noted. Finkelstein's testing was negative. Dr. Greatting recommended an FCE. (PX 5)

Petitioner's attorney wrote to Respondent's attorney requesting authorization for the FCE and accommodation of his client's restrictions or, alternatively, payment of TTD. (PX 13)

Petitioner underwent his functional capacity evaluation on August 5, 2015. The therapist did not have a formal job description from Respondent to review. Petitioner's description of his job indicated he needed to be able to function in the heavy physical demand level as determined by frequent 45 lb. lifts. After the testing was completed, the therapist noted with regard to Petitioner's consistency and quality of effort – "Subjective complaints of pain during testing were inconsistent with displayed function; Heart rate increases during testing would indicate less than full effort; Absence of changes in body mechanics and quality of motion likely indicate self-limiting effort due to subjective complaints of pain and overguarding; and his pain questionnaire packet responses were expected as compared to observations of functional performance that day." (PX 13) The therapist also noted that Petitioner demonstrated decreased left wrist and hand range of motion and decreased wrist and grip strength. Petitioner also displayed limitation in his ability to maintain left grip strength during all lifts, carrying, and pushing/pulling. The therapist noted that Petitioner's Performance Criteria Profile was consistent with over guarded effort and his level of effort indicated he most likely participated with less than full effort. The therapist also noted that Petitioner's willingness to participate in activity showed marked negative effect on observed functional tolerances. It was therapist's opinion within a reasonable degree of medical certainty that petitioner could perform activity on a full-time basis as follows: (1) Lifting – 14 pounds occasional, and 8 lbs. frequent; (2) Pushing/Pulling – pushing 94.5 lbs. and pulling 129.5 lbs. occasionally; (3) Sitting/Climbing/Crawling – Occasional; (4) Reaching/Bending/Squatting/Crawling – Frequent; and (5) Walking – Constant. (PX 10)

Dr. Greatting released Petitioner on October 14, 2015 subject to the permanent restrictions outlined by the therapist in the FCE. He was deemed at maximum medical improvement and told to return if necessary. (PX 5)

By letter dated October 16, 2015 Petitioner's attorney requested accommodation of the permanent restrictions or appropriate benefits and vocational rehabilitation. (PX 13)

Petitioner's case herein proceeded to arbitration on November 18, 2016. At that time both of Petitioner's cases against Respondent (14 WC 10935 and 14 WC 10769) were heard with the understanding that separate decisions would be issued. Michelle Frye was present as Respondent's representative. Two witnesses testified at the hearing: Petitioner and Scott Honnen.

Petitioner testified that he was employed as a machine operator on February 12, 2013 and had been so employed at the Respondent's facility for over one year on a full- time basis. Prior to that Petitioner had worked for Respondent through a temporary agency for one year.

Petitioner testified that on February 12, 2013 he was operating a machine and thought he heard a co-employee call to him. Because of the noise of the machines he was not certain if someone called him. Petitioner turned to see who was speaking to him and struck the inside of his left wrist just below his thumb on the corner of a safety pole. Petitioner testified that it felt like a "stoved toe" but he didn't think much about it.

Petitioner stated that prior to this accident he had not had any problems with his left hand, arm or thumb.

Petitioner testified that he began noticing a loss of strength in his hand after the accident. He went to Passavant Hospital on March 2, 2013 where he was given a splint and told to stay off work for two days.

Petitioner testified that he advised his supervisor about the situation and gave him his off work slip on the Monday following March 2, 2013 as that was the day Petitioner was told to go to Midwest Occupational Health Associates (MOHA). (PX 3) Petitioner testified that he was treated by Dr. Gordon who allowed him to work but continued to monitor him. During this time Petitioner continued to experience pain. Petitioner also testified regarding the care provided to him by Dr. Allan which testimony was consistent with the doctor's medical records.

Petitioner also testified that he underwent a thumb and wrist MRI on July 18, 2013 per Dr. Gordon and thereafter Dr. Gordon declined to further treat Petitioner; however, he told Petitioner that he needed diagnostic testing and imposed no work restrictions. Petitioner testified that despite all that, he was no better. Petitioner further testified that Dr. Gordon discharged him on July 31, 2013 and he sought no further medical care until March 1, 2014 when he was involved in another work accident.

Petitioner testified that while he sought no further treatment after July 31, 2013 he remained symptomatic as he noticed left wrist weakness, limited mobility, a sharp stabbing pain and, on occasion, a tingling sensation in his thumb and wrist area. He continued working full capacity as an operator.

Petitioner testified that on March 1, 2014 he was in another accident while walking a pallet filled with shrink wrapped product (and weighing about 600 lbs.) down an aisle using his right hand to pull the pallet behind him. As he did so another worker pulled another pallet in front of him and let it go right in front of Petitioner so he turned to place both hands on the handle of his pallet to stop it when his left hand slipped off the hand, caught his thumb and bent it back towards his wrist. Petitioner testified to immediately feeling a pop in his hand and wrist followed by pain and throbbing. He told his supervisor immediately but continued working and finished his shift; however, while doing so his complaints worsened and he began to feel a stabbing, slight burning sensation also.

Petitioner testified that he was again sent to Dr. Gordon and he also saw the company nurse. He described swelling in his entire hand and wrist. Petitioner felt the 2014 accident caused the same symptoms as the 2013 accident except for more pain complaints.

Petitioner acknowledged telling Dr. Gordon and the others that he was taking Prednisone for a non-work-related foot problem. He also testified that Dr. Gordon prescribed more Prednisone and had x-rays taken, ultimately releasing him back to full duty. Dr. Gordon also scheduled an MRI.

Petitioner testified that the day after the accident he was put back to work running machines but told his supervisor that he couldn't keep doing that job because he would immediately notice throbbing, severe pain in his hand and wrist when he lifted it or when he tried to hold anything. Petitioner testified to loss of strength in his left hand. He was then moved from being an operator to that of a reliever which meant he went around and filled in for people while on breaks or at lunch. He tried doing relief work for a while but was unable to do it so he was transferred to "rework" where he would open boxes, remove product, and set it aside for "rework" to rerun or fix it.

Petitioner testified to undergoing the MRI. He also testified that "around that time" he separated from his employment with Respondent. He thought it was around March 18, 2014. Petitioner testified that he was thinking of leaving his job with Respondent because he and his

family were having some financial problems and it was getting very hard for them to manage their home. Petitioner also testified that his family was already thinking about moving back to Pennsylvania to be closer to family due to child care issues and he and his wife's schedules. Although terminated from his job with Respondent, Petitioner continued to treat with Dr. Gordon.

According to Petitioner he saw Dr. Gordon on March 24, 2014 at which time the doctor told him that he couldn't offer any further treatment to him, despite his ongoing symptoms. When the doctor examined him on April 7th, he prescribed more Prednisone but still let him work full duty. Their last visit was on April 14, 2014.

Petitioner testified that he began treating with Dr. Greatting on April 23, 2014 and he told him about his 2014 accident and the treatment he had received for it. He also described his symptoms. Dr. Greatting imposed no restrictions at their first visit but did give him an injection. This was followed by a second one and neither one provided any relief.

Petitioner further testified that he returned to see Dr. Greatting on May 29, 2014 at which point the doctor told him he might have reflex sympathetic dystrophy. Petitioner then saw Dr. Narla and underwent a bone scan both of which were authorized by workers' compensation. Dr. Narla prescribed Neurontin and Amitriptyline, the latter being prescribed to help with sleep issues attributable to problems with his thumb/wrist.

Petitioner acknowledged seeing Dr. Williams at the request of Respondent in August of 2014 and that the doctor performed a very thorough exam.

Petitioner testified that he returned to see Dr. Greatting on December 4, 2014 due to ongoing symptoms at which point the doctor suggested he undergo a DeQuervain's release and imposed restrictions. Petitioner proceeded with surgery on February 6, 2015 which was paid for by his wife's insurance carrier. After surgery, Dr. Greatting released him to light duty and prescribed physical therapy which he did at Passavant Hospital. According to Petitioner as of April 27, 2015 he had improved range of motion but not strength. His level of pain had gone down to a 5-6 and changed from feeling like you had a "9 volt battery stuck to your tongue" to a dull ache. Dr. Greatting ordered a functional capacity evaluation that was performed on August 5, 2015. Thereafter, he imposed permanent restrictions of no lifting over 4 pounds occasionally, 8 lbs. frequently, and some other things.

Petitioner testified that he tried several times to contact Respondent about returning to work but he received no response. He looked for work on his own but did not document his job search. Petitioner moved back to Pennsylvania on April 2, 2016. He remains unemployed. He never asked Respondent for help in finding a job.

Petitioner testified that he has reduced range of motion, pain that fluctuates from day to day and with the weather and activities. He had been a volunteer firefighter for seventeen years but can no longer do that. He cannot work in EMS anymore because he cannot lift anyone or carry a stretcher. Petitioner testified that if he tries to lift things with his left hand and arm he drops them. His five year old son has to help him cook dinner and his wife has to assist him opening jars. On occasion she has to cut his meals for him because he cannot hold a knife. Petitioner also testified to problems with his grip and his thumb. When he tries to squeeze or bend his wrist certain ways it becomes more painful. Petitioner testified that he has to alter the way he uses his hand to avoid symptoms. Petitioner acknowledged that he can make a fist. Petitioner is right handed.

On cross-examination Petitioner testified that he always told his doctors the truth about his complaints and how he was doing. He agreed that after the first accident he saw Dr. Gordon and one other doctor, missed no time from work and was able to perform all of his job duties for Respondent when he was released by Dr. Gordon in 2013 albeit with some difficulties. Petitioner acknowledged that July 31, 2013 was the last time he sought any medical care for the first accident and at that point he was released to full duty which he performed through March 7, 2014.

Petitioner testified that he had a second accident on March 1, 2014. He agreed that Respondent worked with him to find easier jobs. Petitioner was unaware of any light duty program by Respondent.

Petitioner also acknowledged having conversations with someone from Respondent regarding separating his employment with Respondent. He also acknowledged mentioning to individuals that he was going to leave the State for financial reasons. He also agreed that Respondent knew he was considering leaving his position with it and that he was informed that it had considered him as having resigned his position adding that he voiced his opinion that he was considering leaving but not that he was actually physically doing that. He also agreed that earlier in the year 2016 he did leave the State for financial reasons. Petitioner testified that "they" called

him on March 18, 2014 at 8 a.m. to let him know that he no longer worked for Respondent and then around 9:30 a.m. he got a call from the medical staff telling him they had received his MRI and that it showed he had arthritis in his left wrist but was, otherwise, normal. He also agreed that Dr. Gordon last saw him in April of 2014.

Petitioner testified that he went to Dr. Greatting because other people, and not his attorney, had recommended him. Petitioner acknowledged the functional capacity evaluation. When asked if he remembered a notation about submaximal effort being given Petitioner replied "No." and added that from his review of the report he had given ample participation in the evaluation. Petitioner also testified that at that time he would try to help run the sweeper at home, feed the dogs, and help bathe his son and do other daily activities. He agreed that lifting bothered his wrist and carrying objects bothered his wrist.

Petitioner could not recall the dates of any conversations with Respondent regarding attempts to go back to work although they would have been in 2014. He denied being employed in any capacity since his separation with Respondent.

Scott Honnen testified on behalf of Respondent. He has worked for Respondent for 27 years, the last ten of which have been as a unit manager on the manufacturing side of the business. Mr. Honnen testified that Respondent has a light duty program which involves trying to find work for injured employees who have restrictions.

Mr. Honnen testified to knowing Petitioner through his employment with Respondent. It was his understanding that Petitioner resigned because he was moving out of state. If Petitioner had light duty restrictions after March of 2014 Respondent would have considered him for a light duty job.

On cross-examination Mr. Honnen testified that he didn't know if Petitioner was ever sent a termination letter. He agreed that he had never spoken directly with Petitioner about his employment status. He never saw a resignation letter from Petitioner but that, in some cases, there are such letters. He did not know anything about Petitioner's application for unemployment.

Petitioner was called on rebuttal and testified that he applied for unemployment after he was terminated but it was denied. He received a document stating he was unable to work due to a medical condition. He also agreed that no one from Respondent ever contacted him offering him light duty.

The Arbitrator concludes:

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

Petitioner failed to prove that his current condition of ill-being in his left thumb and wrist is causally connected to his accident of February 12, 2013. In so concluding the Arbitrator notes the absence of any opinion from a treating doctor establishing a causal connection between Petitioner's February 12, 2013 accident and his current condition of ill-being in his left hand, wrist, and thumb. Additionally, Petitioner sustained an accident on March 1, 2014 that broke any chain of causation. However, Petitioner did prove causal connection through July 31, 2013.

Petitioner last treated for his February 12, 2013 accident on July 31, 2013. At that point in time, Dr. Gordon released Petitioner from his care and Petitioner continued working full duty for Respondent at his regular job.

After Petitioner's March 1, 2014 accident Petitioner began treating once again. With regard to all of the providers he saw thereafter, Petitioner gave an onset date of March 1, 2014. He did not indicate he felt his symptoms or complaints stemmed from his February 12, 2013 accident.

In summary, Petitioner did sustain an accident on February 12, 2013; however, he reached maximum medical improvement for any injuries stemming from that accident on July 31, 2013.

Issue (J) Were the medical services that were provided to Petitioner reasonable and necessary?:

Petitioner is awarded the following medical bills found in PX 6 as the Arbitrator finds them to be reasonable, necessary and causally related to the accident:

Clinical Radiologists, 7/18/13	$ 99.45
JCH Medical Group, 5/22/13	$ 219.00
Total	$ 318.45

Said bills are awarded pursuant to the Medical Fee Schedule.

Issue (K) Temporary Total Disability (TTD) Benefits.

Petitioner is denied any award of TTD benefits in connection with this claim. Petitioner seeks TTD benefits from August 13, 2014 through October 14, 2015. However, no doctor took

Petitioner off work during the foregoing time period, or imposed work restrictions, on account of the February 12, 2013 accident.

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

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 an operator for Respondent at the time of his accident. He testified that he continued working full duty throughout the time period he treated for this injury. While he is no longer employed by Respondent, that is not on account of this accident or the injury he sustained. The Arbitrator gives this factor some weight.

(iii) Age: Petitioner was 37 years old at the time of his accident. 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. Petitioner did not testify to any change in earnings or earning capacity as a result of this accident. While currently unemployed, that status is not on account of this accident. The Arbitrator gives no weight to this factor.

(v) Disability: When last seen by Dr. Gordon on July 31, 2013 Petitioner had some tenderness in the first dorsal compartment and in the region of the left first metacarpal. However, there was no indication of any edema and he had full range of motion of all joints in his left thumb and wrist. Petitioner had undergone an MRI that failed to reveal any abnormality in the areas where Petitioner was reporting subjective complaints. Petitioner was advised to use Theraputty and that his symptoms would be self-limiting. Over the course of his treatment Petitioner received one injection, medication, a thumb spica brace, and instructions to use "caution" when working.

Petitioner testified at arbitration that he continued to experience left wrist weakness, limited mobility, a sharp stabbing pain, and occasionally, a tingling sensation in his thumb and wrist area. He acknowledged that, despite these symptoms, he sought no further medical care. The Arbitrator notes that when Petitioner began treating after his

accident on March 1, 2014 he provided no doctor or therapist with any information suggesting ongoing difficulties with his left thumb, wrist, or hand, after being released by Dr. Gordon in July of 2013.

Having considered the foregoing factors, the Arbitrator concludes that Petitioner is now permanently partially disabled to the extent of 5% loss of use of the left hand as provided in Section 8(e) of the Act.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ryan Kmieciak,

Petitioner,

vs.

NO: 14 WC 10935

Reynolds Consumer Products Inc.,
d/b/a Pactiv Corp.,

18IWCC0371

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 of current condition of ill-being, medical bills, temporary total disability, and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes that the parties consolidated this case with an earlier case (case number 14 WC 10769) involving identical parties and a prior injury to Petitioner's left hand on February 12, 2013. The Commission has rendered a separate Decision in the companion case.

Findings of Fact

In the interest of efficiency, the Commission primarily relies on the Arbitrator's detailed recitation of the facts. On March 1, 2014, Petitioner injured his left hand, wrist, and thumb while trying to stop the forward progress of a pallet by pushing against the pallet that weighed approximately 600 lbs. Petitioner testified that he felt a pop in his left hand and wrist and felt immediate pain and throbbing. Petitioner testified that he experienced the same symptoms he felt following the February 2013 injury; however, his symptoms following the March 2014 accident were more intense and debilitating. Petitioner's doctors initially cleared him to work without restrictions; however, Petitioner had significant complaints of pain, and Respondent found other duties for Petitioner to perform. (Tr. at 41-42). Petitioner testified that on March 18, 2014, Scott Honnen, a unit manager with Respondent, informed Petitioner that he no longer worked for Respondent. *Id.* at 42-43. Petitioner testified that Mr. Honnen said Petitioner had already given two weeks' notice. Petitioner denied giving any notice to Respondent. Petitioner admitted he was

thinking of moving back to Pennsylvania to be closer to family because Petitioner's family was having financial troubles. *Id.* at 44. Petitioner also admitted telling someone at the company and several other individuals that he planned to leave Illinois. *Id.* at 64. Petitioner testified someone told him that the company considered his statements regarding leaving to be a resignation. Mr. Honnen testified that he believed Petitioner gave his resignation to Respondent because Petitioner was moving out of state. *Id.* at 77-78.

Mr. Honnen testified that Respondent has an established light duty program through which the company finds work within an injured worker's restrictions. *Id.* at 76. He testified that the light duty program existed in 2013 and 2014. Mr. Honnen testified that Respondent would have considered Petitioner for a light duty position if he still worked at the company. *Id.* at 79. Petitioner initially received conservative treatment including physical therapy and a corticosteroid injection. However, Petitioner continued to complain of significant pain in his left hand and wrist. Dr. Williams, Respondent's IME doctor, examined Petitioner on August 13, 2014. (RX 6). After taking a history from Petitioner, Dr. Williams wrote, "He put in his 2-week notice February to leave. He got a call on 3/19/2014 and told him he no longer had a job." Dr. Williams questioned whether Petitioner had developed CRPS of the left hand due to Petitioner's extreme hypersensitivity to touch. The doctor referred Petitioner to a neurologist for evaluation of possible CRPS and determined Petitioner was not yet at MMI. Dr. Williams also prescribed work restrictions of no use of the left hand. A September 2014 bone scan later ruled out the questionable CRPS diagnosis. On February 6, 2015, Petitioner underwent a release of the left wrist de Quervain's tenosynovitis.

Petitioner participated in an FCE on August 5, 2015. Respondent did not provide job requirements so the therapist relied on Petitioner's self-reported job description which placed his job in the heavy category. (PX 10). The therapist determined Petitioner had the following capabilities relating to the left wrist: occasional lifting up to 14 lbs. and 8 lbs. frequently, pushing occasionally up to 94.5 lbs., pulling occasionally up to 129.5 lbs., occasional sitting, climbing, and crawling, and frequent reaching, bending, squatting, and kneeling. *Id.* However, Petitioner exhibited questionable effort throughout the exam. The therapist noted that Petitioner's performance was consistent with self-limiting effort. *Id.* He further noted that Petitioner's subjective complaints of pain were inconsistent with his displayed function. The therapist noted Petitioner most likely participated with less than full effort; additionally, Petitioner's willingness to participate in an activity had a marked negative effect on observed functional tolerances. *Id.* Dr. Greatting placed Petitioner at MMI and prescribed permanent restrictions as outlined in the results of the FCE on October 14, 2015. (PX 5). Petitioner testified that Dr. Greatting prescribed permanent restrictions that included no lifting over 4 lbs. occasionally and no lifting over 8 lbs. frequently.

Conclusions of Law

After carefully considering the totality of the evidence, the Commission reverses the Arbitrator's award of temporary total disability ("TTD"). The Commission modifies the Arbitrator's nature extent award.

Temporary Total Disability

The Arbitrator awarded TTD to Petitioner from August 13, 2014 (the date of Dr. Williams' IME), through October 14, 2015 (the date of MMI). The Arbitrator based this award on the evidence that Respondent's IME doctor gave Petitioner light duty restrictions beginning August 13, 2014, and Dr. Greatting continued to provide light duty restrictions thereafter.

After reviewing the evidence, the Commission finds Petitioner did not meet his burden of proving an entitlement to TTD. "A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character or his injury will permit." *Westin Hotel v. Indus. Comm'n*, 372 Ill. App. 3d 527, 542 (2007). When considering the issue of TTD benefits, the dispositive inquiry is whether the claimant has reached MMI. *See Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n*, 236 Ill. 2d 132, 142 (2010). Illinois courts recognize three exceptions when an employer can suspend or terminate TTD benefits before an employee reaches MMI: 1) if the employee refuses to submit to medical, surgical, or hospital treatment essential to his recovery; 2) if he refuses to cooperate in good faith with rehabilitation efforts; or 3) if the employee refuses work falling within the physical restrictions prescribed by his doctor. *Id.* at 146-47.

Petitioner testified that he never resigned from his job with Respondent. On cross-examination, Petitioner admitted that he told people that he planned to leave Illinois. (Tr. at 64). Petitioner admitted he spoke with someone at the company regarding leaving his job because he planned to move out of state. *Id.* at 64-65. Petitioner did not produce any witnesses to corroborate his allegation that he never resigned and only told people he was thinking about moving. Petitioner testified that he never told anyone a specific moving date. *Id.* at 43. Petitioner testified that he and his wife were planning to move due to ongoing financial and family concerns. *Id.* at 44. Petitioner did eventually move out of state in 2016. Mr. Honnen, a longtime unit supervisor with Respondent, testified that Petitioner gave his resignation to the company and Petitioner identified the reason as a planned move out of state. Although Mr. Honnen was unaware of any resignation paperwork completed by Petitioner, he testified that not every employee resigns in writing.

The Commission finds Mr. Honnen was a credible witness. Mr. Honnen testified credibly regarding his knowledge of the circumstances surrounding his March 18, 2014, call to Petitioner. Petitioner spoke with someone at the company regarding leaving his employment with Respondent due to an out of state move. Petitioner did not produce any witnesses to corroborate his allegation that he never resigned. The Commission notes that the history Petitioner gave to Dr. Williams during the August 2014 IME further supports the finding that Petitioner resigned from his employment with Respondent. Dr. Williams noted that Petitioner gave his two weeks' notice in February and received a call on March 19, 2014, that he no longer had a job with Respondent. The Commission finds Petitioner failed to meet his burden of proving the Respondent unilaterally terminated him in March 2014.

When Petitioner resigned, he effectively refused work that fell within the restrictions prescribed by his doctor. In March 2014, no doctor had provided any work restrictions for Petitioner. During this period, Dr. Gordon cleared Petitioner to continue working full duty. Yet when Petitioner complained that his job duties increased his pain, Respondent voluntarily found

other duties for Petitioner that did not increase his symptoms. No doctor imposed work restrictions prior to Dr. Williams' August 2014 IME. Additionally, no doctor ever restricted Petitioner completely from work; instead, Dr. Greatting continued to prescribe various light duty work restrictions. Petitioner testified that he was unaware of any light duty program at Respondent. This testimony is disingenuous. Mr. Honnen testified that Respondent has a light duty program where the company works to accommodate the needs of injured employees. Mr. Honnen also testified that the light duty program was in place in 2013 and 2014. Mr. Honnen credibly testified that Respondent would have tried to accommodate any work restrictions if Respondent still employed Petitioner. Petitioner's own testimony supports Mr. Honnen's testimony that the company worked hard to accommodate the needs of its injured employees. After all, Respondent had a proven record of making accommodations for employees even without restrictions prescribed by a doctor. Respondent's willingness to make accommodations based solely on Petitioner's subjective complaints proves the company had a robust light duty program.

For the foregoing reasons, the Commission finds that Petitioner failed to prove he met the requirements to receive TTD from August 13, 2014, through October 14, 2015. Therefore, the Commission reverses the Arbitrator's award of TTD in its entirety.

Nature and Extent

As the date of accident occurred after the effective date of the amendment, an analysis pursuant to §8.1b of the Act is necessary. The Act states that "... [n]o single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order." §8.1b(b). The Arbitrator weighed all five factors and determined Petitioner suffered a 30% loss of the whole person due to this work accident. The Commission views the evidence differently than the Arbitrator. After carefully considering the evidence, the Commission finds Petitioner sustained a 30% loss of use of the left hand due to the this work accident.

(i) The reported level of impairment pursuant to subsection (a)

Neither party produced an AMA impairment rating. Thus, the Commission assigns no weight to this factor.

(ii) The occupation of the injured employee

Petitioner worked as a machine operator. He testified that his duties included stacking the finished product, including plastic trash bags and cases of cartons, onto a pallet. Once he stacked everything on a pallet, he would shrink wrap the pallet contents and use a manual pallet jack to pull the pallet to a different location. Petitioner estimated a pallet could weigh up to 600 lbs. Petitioner also rotated between different duties if another area needed coverage. Petitioner described his job as heavy duty to the therapist who conducted the FCE. Respondent did not provide any evidence showing Petitioner did not accurately describe his work duties. As operating machines and pushing and pulling heavy pallets is physically demanding, the Commission assigns some weight to this factor.

(iii) The age of the employee at the time of the injury

Petitioner was 37 years old on the date of accident. Thus, it is reasonable to expect he will live with the residual pain and symptoms from the work accident for many years. Thus, the Commission assigns some weight to this factor.

(iv) The employee's future earning capacity

On the date of hearing, Petitioner was unemployed and lived in Pennsylvania. Petitioner testified that he began a job search sometime after his employment with Respondent ended. Petitioner testified that he contacted Respondent several times regarding a possible return to work but never received a response. However, Petitioner could not provide any details regarding these alleged calls other than they occurred sometime in 2014. Likewise, Petitioner testified that he conducted a job search but did not document his search. Although Petitioner remained unemployed on the date of hearing, Petitioner did not provide any credible evidence that this work injury affected his future earning capacity in any way. There is also no evidence that Petitioner's unemployment was due to this work accident. The Commission finds Petitioner failed to prove his work injury had an impact on his future earning capacity. Thus, the Commission assigns some weight to this factor.

(v) Evidence of disability corroborated by the treating medical records

Petitioner sustained an injury to his left hand, wrist, and thumb that required surgical intervention. He was diagnosed with de Quervain's tenosynovitis. While Petitioner testified that the surgery improved his symptoms, he also complained of severe chronic residual symptoms from the work injury. Petitioner last saw Dr. Greatting on October 14, 2015.

Petitioner testified that his pain is usually around a 5-6/10 and it feels like a dull ache. He testified that he still has reduced range of motion, weakness, and pain that fluctuates each day with the weather or activity. He testified that he is no longer able to work as a volunteer firefighter or EMS. He testified that when he tries to lift things such as a jar of pickles with his left hand, he often drops items. He testified that his wife opens jars for him and some days his wife must cut his meal because Petitioner is unable to hold a fork or knife. Petitioner testified that his wife and son help him cook dinner. However, despite these significant chronic symptoms he never sought any additional treatment relating to this work injury.

Much like the Arbitrator, the Commission has deep concerns regarding Petitioner's credibility. Throughout his treatment, Petitioner's doctors and therapists noted that objective tests did not support Petitioner's complaints of extreme pain. Petitioner testified that the surgery improved his symptoms, yet he testified to having seemingly less function now in his left hand than he exhibited during his final office visits. Petitioner testified that he did not know if Respondent had a light duty program, but he admitted that Respondent provided accommodations for Petitioner's complaints even when his doctor cleared Petitioner to continue working full duty. Likewise, Petitioner testified that Dr. Greatting's permanent restrictions included occasional lifting up to 8 lbs. and frequent lifting up to 4 lbs. In fact, Dr. Greatting's restrictions allowed occasional lifting up to 14 lbs. and frequent lifting up to 8 lbs.

The results of Petitioner's August 2015 FCE are particularly troubling. The examining therapist carefully documented the many ways in which Petitioner gave questionable effort throughout the examination. He noted that Petitioner's performance was consistent with self-limiting effort and that Petitioner's subjective complaints of pain were inconsistent with his displayed function. The therapist noted that Petitioner most likely participated with less than full effort and that Petitioner's willingness to participate in an activity had a marked negative effect on his observed functional tolerances. Furthermore, when asked on cross-examination whether he understood that there were indications that he did not give full effort during the FCE, Petitioner responded, "Actually from what I remember from reading the report...it said that I gave ample participation in my evaluation." (Tr. at 71-72). This is yet another example of Petitioner providing less than credible testimony. Petitioner's lack of effort during the FCE leads the Commission to believe the results of the FCE do not reflect Petitioner's true work capabilities.

The Commission finds Petitioner did not meet his burden of proving he suffered a loss of occupation due to his work injury. Petitioner did not provide credible evidence that he was unable to return to his original occupation as a machine operator with the permanent restrictions prescribed by Dr. Greatting. Dr. Greatting did not opine that Petitioner was unable to return to his job as a machine operator. There is no credible evidence that Petitioner ever sought work as a machine operator after Dr. Greatting prescribed permanent restrictions. Furthermore, Petitioner voluntarily resigned from his job with Respondent and moved to Pennsylvania. When his resignation became effective, there is no dispute that Respondent made several accommodations to Petitioner's work duties based on Petitioner's subjective complaints. Given the issues discussed herein, the Commission assigns significant weight to this factor.

After carefully weighing all of the evidence, as well as the credibility of the witnesses, the Commission finds Petitioner is not entitled to an award pursuant to §8(d)(2). Therefore, Commission modifies the Decision of the Arbitrator and finds Petitioner suffered a 30% loss of use of the left hand.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 19, 2017, is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner permanent partial disability benefits $327.00/week for 61.5 weeks, because the injuries sustained caused the 30% loss of use of the left hand, as provided in Section 8(e) of the Act.

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

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

18IWCC0371

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,205.00. 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 12 2018

o: 3/20/18
TJT/jds
51

Michael J. Brennan

Kevin W. Lamborn

DISSENT

I respectfully dissent from the opinion of the majority and would affirm and adopt the Arbitrator's Decision. After a careful review of the evidence, I believe Petitioner met his burden of proving by a preponderance of the evidence an entitlement to temporary total disability, and that he suffered a loss of occupation due to the March 1, 2014, work accident.

Both the majority and the Arbitrator raised issues regarding Petitioner's credibility in this case. However, the majority has reached a vastly different conclusion than that of the Arbitrator. I believe the Arbitrator properly weighed all the evidence and awarded proper weight to any perceived deficiencies in Petitioner's testimony. The majority's opinion that Petitioner did not meet his burden of proving that he qualified for TTD benefits and suffered a loss of occupation due to this work injury is not supported by the evidence.

I believe the majority improperly determined Petitioner voluntarily resigned from his position at Respondent. Petitioner admitted that he spoke to various individuals, including at least one person at Respondent, regarding his intention to leave Illinois. Petitioner testified that he never gave two weeks' notice to anyone at Respondent and instead only told people that he was considering leaving his job and moving to Pennsylvania. Mr. Honnen called Petitioner on or about March 18, 2014, and informed Petitioner that the company considered Petitioner's statements as a notice of resignation. He stated Petitioner's employment with Respondent had ceased. Mr. Honnen admitted that Petitioner never told him that he planned to move and leave his job. In fact, Mr. Honnen admitted that it was only his "understanding" that Petitioner had resigned because he was moving out of state. Respondent chose not to present the person to whom Petitioner allegedly gave notice and instead presented a witness who had no firsthand knowledge of Petitioner's alleged resignation. I believe Respondent's failure to present this witness raises questions regarding

whether this individual's testimony would have been harmful to Respondent's defense. There is no credible evidence that rebuts Petitioner's testimony that he only told people he was considering a move to Pennsylvania.

The majority bases its denial of TTD benefits on its erroneous conclusion that Petitioner voluntarily resigned from his employment. Petitioner testified that Dr. Greatting never cleared him to return to work full duty. The medical records as well as Respondent's own IME report show that Petitioner had significant work restrictions beginning August 13, 2014. Dr. Greatting then continued to prescribe significant work restrictions up to October 14, 2015, the date he placed Petitioner at MMI. As Respondent chose to terminate Petitioner's employment in March 2014, the company is responsible for paying TTD benefits during the entire period when Petitioner had work restrictions prior to the date of MMI. Respondent does not get to unilaterally fire Petitioner and later avoid paying TTD benefits because the company could have accommodated Petitioner's restrictions if he still worked for the company. Thus, the Arbitrator correctly determined Petitioner was entitled to TTD from August 13, 2014, through October 14, 2015.

Inexplicably, the majority determined that Petitioner failed to prove he sustained a loss of occupation due to this work accident. Petitioner suffered an injury to his left hand, wrist, and thumb on the date of accident. This injury aggravated Petitioner's pre-existing osteoarthritis and de Quervain's tenosynovitis. Petitioner testified that his symptoms were magnified and more debilitating following this work accident. The medical records show Petitioner consistently complained of high levels of pain and discomfort following the work accident. After a neurologist ruled out a diagnosis of CRPS of the left hand and wrist, Petitioner underwent surgery. The medical records show that while Petitioner's symptoms improved following the surgery, they never completely resolved.

Although the majority places great weight on certain portions of the FCE report, no medical professional deemed the results invalid. Dr. Greatting did not express any concern regarding the therapist's observations and the results of the examination. Dr. Greatting was the medical provider most familiar with Petitioner's condition and his recovery. The medical records show that Dr. Greatting adopted permanent restrictions that reflected the capabilities shown in Petitioner's FCE without reservation. I believe the majority has improperly minimized the only medical opinion regarding Petitioner's capabilities. After all, Respondent did not obtain an IME to challenge the permanent restrictions prescribed by Dr. Greatting or the validity of the FCE results.

Because of this work accident, Petitioner has significant permanent work restrictions. Petitioner testified that his job as a machine operator was heavy duty and required him to repetitively lift and pull heavy items throughout the day. Respondent did not present any evidence contradicting Petitioner's testimony regarding his various job duties. Respondent also did not submit a job description to the FCE examiner. No doctor has opined that Petitioner could return to his job as a machine operator with the permanent restrictions prescribed by Dr. Greatting. While I agree that Respondent has a history of accommodating the needs of injured employees when possible, I disagree with the majority's opinion that evidence of past temporary accommodations proves the company would have also accommodated Petitioner's permanent restrictions. Mr. Honnen testified that Respondent would have *tried* to accommodate Petitioner's temporary restrictions if the company still employed him. However, there is no guarantee Respondent could

have accommodated Petitioner's permanent restrictions. Without proof that Respondent would have accommodated the permanent restrictions, I believe there is more than ample evidence supporting a finding that Petitioner sustained a loss of occupation due to the work accident.

For the forgoing reasons, I would affirm and adopt the Arbitrator's Decision in its entirety.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KMIECIAK, RYAN
Employee/Petitioner

Case# **14WC010935**

14WC010769

REYNOLDS CONSUMER PRODUCTS INC D/B/A PACTIV CORPORATION
Employer/Respondent

18IWCC0371

On 1/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2934 BOSHARDY LAW OFFICE PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

STATE OF ILLINOIS)
) 18IWCC0371
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

Ryan Kmieciak
Employee/Petitioner

Case # **14** WC **10935**

v.

Consolidated w/14 WC 10769

Reynolds Consumer Products, Inc. d/b/a Pactiv Corporation
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **November 18, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned $ **29,172.00** ; the average weekly wage was $ **545.00** .

On the date of accident, Petitioner was **37** years of age, ***married*** with **1** dependent child.

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 for $**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** 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 Petitioner temporary total disability benefits of $ **363.33**/week for **62 & 1/7** weeks, commencing **August 13, 2014** through **October 14, 2015** , as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $ **327.00**/week for **150** weeks, because the injuries sustained caused **30** % loss of the person as a whole as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **March 1, 2014** through **November 18, 2014** , and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary and causally related medical bills of $ **22,784.41**, subject to the medical fee scheduled, 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.

Nancy Lindsay
Signature of arbitrator

January 16, 2017
Date

JAN 19 2017

Ryan Kmieciak vs. Reynold's Consumer Products d/b/a Pactiv Corporation, 14 WC 10935

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner was involved in an undisputed work accident on February 12, 2013. (AX 1) At that time Petitioner struck his left hand on a metal pole. Petitioner sought no immediate medial care.

Petitioner sought treatment at Passavant Area Hospital on March 2, 2013. He informed the emergency room staff of the accident, noting that two weeks before he had struck his left hand on a metal pole and was experiencing pain shooting up his forearm. (PX 7) Petitioner's pain drawing noted tenderness in his left thumb on both the top and bottom. (PX 7) X-rays of Petitioner's left hand and thumb were negative. (PX 7) Petitioner was examined, diagnosed with a contusion, placed in a thumb spica splint, removed from work for two days and referred to Dr. Greene for follow-up care. (PX 7)

Petitioner was next seen by Nurse Practitioner Jane Kamp at Midwest Occupational Health Associates (MOHA) on March 4, 2013 regarding his left thumb pain. Petitioner advised N.P. Kamp of the accident wherein he hit his left thumb on a metal pole. Petitioner reported that he continued working thereafter and that his regular job was that of a carousel operator; however, if another worker was sick or a fill-in was needed he would help out (but this was rarely). Petitioner further informed Ms. Kamp that he was loading a machine with cardboard boxes which required him to grab 30-40 boxes at a time and put them in the machine. He would use his left hand and did so 56 times in one hour which did not include doing drawer tape and other tasks. Petitioner remarked that he had counted the repetitions and believed it "had a high incidence for injury potential." Petitioner reported difficulty squeezing with his left hand and informed Ms. Kamp of his visit to the ER Department on Saturday[1] at which time he was given a brace. On examination Ms. Kamp noted Petitioner's left wrist had mild decreased range of motion upon flexion and extension. He was "excessively hypersensitive" to light touch of his left wrist and left thumb and hand. She could not appreciate any edema or erythema in his left hand, wrist or thumb. He moved his thumb and fingers very cautiously. Petitioner was diagnosed with left thumb pain and prescribed Ibuprofen three times a day along with Extra Strength Tylenol. He was to also use ice on his left hand and thumb as needed. He was cleared for work but told to use caution at work

and "not utilize his support [brace] more than 6 hours per work shift and to not utilize it in his nonworking and sleeping hours." Petitioner's pain drawing indicated Petitioner had stabbing pain on the top of his left hand and thumb up into his forearm. Petitioner rated his pain as a six out of ten. (PX 3)

Petitioner was then seen by Dr. Robert Gordon at MOHA on March 8, 2013 where it was noted that Petitioner had increased pain in the region of his dorsal compartment and that his work activities were causing his symptoms to continue and worsen. (PX 3) On examination Dr. Gordon noted a positive Finkelstein's test and he diagnosed Petitioner with DeQuervain's Syndrome and prescribed Prednisone. He did not restrict Petitioner's work activities although he advised Petitioner to "use caution with his left upper extremity." Dr. Gordon's notes indicate that he also explained this to Mark Strubble, Respondent's safety director. After the course of Prednisone, Petitioner was to go back on Ibuprofen. He was further told to check in with nursing routinely. Dr. Gordon wished to see him again in two weeks, further noting that if there no improvement at that time, consideration would be given to an injection. (PX 3)

As instructed, Petitioner followed up with Dr. Gordon on March 20, 2013. Petitioner reported some improvement in his left thumb but continued pain with performing certain work activities and at the region of the first dorsal compartment near the thumb. Petitioner was told to continue with the Ibuprofen and Extra Strength Tylenol, along with ice and heat as needed. He, again, was instructed to utilize caution while performing his regular work. (PX 3)

Petitioner returned to Dr. Gordon on April 12, 2013 noting that he continued to be symptomatic. Petitioner had tenderness in the region of the first dorsal compartment and a positive Finkelstein's. Dr. Gordon injected Petitioner's left first dorsal compartment and released Petitioner to return to work without restrictions but, again, with "caution." (PX 3)

On May 10, 2013 Petitioner returned to Dr. Gordon reporting that he was 80 to 85% better since undergoing the injection. However, his primary pain was noted to be in the thumb MCP joint region and in the ulnar aspect of the thumb MCP joint. He denied any gross instability sensation or other numbness or tingling in the left hand. On examination Petitioner lacked any gross tenderness in the first dorsal compartment. He did have mild tenderness of the left thumb in the region of the ulna collateral ligament but no edema. Petitioner had excellent pinch grip strength and lacked any laxity in comparison to the right. Dr. Gordon's impression was that of

[1] 3/2/13

left DeQuervain's Syndrome by history although Petitioner was doing much better after the injection. Petitioner remained symptomatic in the region of the left thumb MCP joint ulnarly. He was prescribed Mobic one tablet per day and, again, told to use caution at work. If he failed to improve when re-examined in four weeks, an MRI would be considered. (PX 3)

Petitioner then sought care from Dr. Randall Voigts on May 22, 2013 to establish care. Petitioner advised Dr. Voigts of the work accident in February and his continued wrist pain but he was not specifically seeking care for that problem as it was being treated by Dr. Gordon. Nevertheless, Dr. Voigts noted Petitioner had left hand pain, at the base of the thumb on the left hand. Dr. Voigts noted Petitioner had a positive Finkelstein's test and he recommended that Petitioner "ask about seeing an orthopedist". (PX 11)

Petitioner returned to Dr. Gordon on June 7, 2013 noting continued pain in the left thumb with the majority of his symptoms located in the left thumb metacarpal between the MCP to CMC joints. Petitioner also reported the Mobic wasn't helping. On exam, he lacked any tenderness in the region of the first dorsal compartment or edema. Dr. Gordon noted a negative Finkelstein's test. Petitioner had full range of motion at the CMC joint and MCP joint of the left thumb. Petitioner had tenderness in the region of the first metacarpal but no edema. There were no issues with thumb opposition or neurovascular abnormalities. Petitioner's diagnoses remained unchanged. Dr. Gordon recommended an MRI of the left hand and wrist due to left radial wrist pain, Voltaren rather than Mobic, and ongoing caution with work activities. (PX 3)

Petitioner underwent the MRI on July 18, 2013. The MRI was positive for mild osteoarthritis of the carpometacarpal and metacarpophalangeal joints. (PX 4) There was also mild tenosynovitis of the second and first extensors in the left wrist. (PX 3, 4) In a chart note dated July 24, 2013 Dr. Gordon discussed the results with Petitioner, noting the radiologist who read them was a radiological musculoskeletal specialist. He did not recommend any further diagnostic studies or therapeutic interventions but noted he would be recommending that Petitioner use Theraputty and engage in home exercises. (PX 3)

Petitioner returned to see Dr. Gordon on July 31, 2013 noting continued pain and tenderness of the first metacarpal. On exam the doctor noted tenderness in the first dorsal compartment and in the region of the left first metacarpal. No edema in either region was noted and he had full range of motion in all joints of the left thumb and wrist. Dr. Gordon noted his discussion with Petitioner stating that the MRIs did not reveal any abnormality in the areas where Petitioner

complained of pain. Petitioner was told his symptoms would be self-limiting and he was instructed in the use of Theraputty. Petitioner was discharged from care. (PX 3)

Petitioner underwent no further medical care between July 31, 2013 and March 7, 2104.

On March 7, 2014 Petitioner again presented to Dr. Gordon. As part of the exam Petitioner completed a questionnaire in which he noted he had a current condition of arthritis in his left two fingers and thumb from a previous injury. At that time Petitioner reported that on/about March 1, 2014 he was operating an electric hand jack and had to stop suddenly resulting in his left hand slipping off the handlebar and his left wrist and thumb being twisted. Since then Petitioner had noticed pain. Petitioner had not undergone any x-rays and he reported that he was currently on Prednisone for plantar fasciitis which wasn't really helping. Petitioner, on exam, had diffuse swelling of his left wrist and hand with exquisite tenderness over the first dorsal compartment of his left wrist and his dorsal wrist, generally. He also had tenderness of his left dorsal hand but not as much as in the wrist. Petitioner was unable to make a handgrip on the left due to pain and swelling. A pain drawing was completed by Petitioner and Petitioner described his symptoms as very intense (ie. unable to perform daily tasks/unable to perform job). Dr. Gordon's impression was left wrist/hand pain with edema and he ordered an x-ray of both Petitioner's hand and wrist. He also recommended Tylenol and wished to see him later that day after completion of the x-rays. (PX 3)

X-rays were performed at the Springfield Clinic on March 7, 2014 due to Petitioner's "jamming of his hand and wrist backwards." They were read as negative. (PX 5) Given Petitioner's complaints and notable swelling, an MRI was recommended at that time. In the interim Petitioner was allowed to perform full duty work "with caution." (PX 3)

Petitioner stopped working for Respondent on March 11, 2014. (RX 6, p. 1, para. 2)

The MRI was performed at the Springfield Clinic on March 18, 2014 revealing osteoarthritis of the left metacarpophalangeal joint and the trapezio-scaphoid. (PX 3, 5)

Petitioner's employment with Respondent ended on/about March 19, 2014. (RX 6, p. 1, para. 2)

On March 24, 2014 Petitioner returned to Dr. Gordon who noted continued symptoms in Petitioner's left upper extremity, especially in the area of the dorsal thumb region, radial wrist region, and his distal radial forearm region. Petitioner was really uncertain if he was improving or not and was unable to tolerate the Naprosyn and, therefore, wasn't utilizing any medication at

the present. He was also using a left thumb spica that had previously been issued to him by Dr. Gordon. Petitioner also reported that he was no longer working for Respondent. On examination Petitioner had tenderness to very light palpation of his left dorsal thumb region, radial wrist region, and distal radial forearm region. Dr. Gordon noted that Petitioner had significant withdrawal with just barely touching his skin and difficulty making a fist. Petitioner's edema was notably improved and he was able to move each of the joints of his thumb. Dr. Gordon's impression was left upper extremity pain, most notably of the radial forearm, wrist and dorsal thumb region. Overall, Petitioner's clinical exam was improved from his last exam. Dr. Gordon described Petitioner's examination of that date as "notably nonphysiologic" and based upon Petitioner's reported mechanism of injury the doctor could not conclude that Petitioner's current symptomology was related to a mechanical disorder secondary to the workplace as has been described to him within a reasonable degree of medical certainty. He recommended Relafen, continued use of the thumb Spica case, Theraputty, and follow-up in two weeks, or sooner, if needed. Petitioner was cleared to perform all job functions associated with his regular job duties albeit "with caution." (PX 3)

Petitioner signed his Application for Adjustment of Claim in case # 14 WC 10769 on March 24, 2014 alleging a left hand/thumb injury on February 12, 2013. (PX 1)

Petitioner signed his Application for Adjustment of Claim in case # 14 WC 10935 on March 24, 2014 alleging a left hand/thumb injury on March 1, 2014. (PX 1)

On April 7, 2014 Dr. Gordon re-examined Petitioner who reported continued pain, inability to make a fist, and a pulling sensation when flexing his thumb. He did not feel like he was improving. (PX 3) On examination Dr. Gordon noted slight edema in the left wrist and thumb, tenderness to touch in the left dorsal and thumb area, and a hypersensitivity to light touch. Dr. Gordon again prescribed Prednisone and told Petitioner to use his thumb Spica splint at bedtime. (PX 3)

On April 14, 2014 Petitioner returned to Dr. Gordon reporting extensive swelling of his left wrist and hand for the previous two nights without any other incident. Dr. Gordon wrote, " I had been treating him for a reported work related incident with regard to his left upper extremity. I did discuss with him I can't explain why he would have such symptomatology of his left upper extremity at this point due to his reported work-related incident, especially given his reported mechanism of injury." Dr. Gordon examined Petitioner's left hand and wrist noting tenderness

to palpation, diminished range of motion of the wrist in all planes, edema of the left hand. With Finkelstein's maneuver Dr. Gordon was unable to accurately assess for it as Petitioner had symptomatology just with the initiation of the maneuver. Dr. Gordon further noted that, when asked, Petitioner could not make a fist but when "observed" he could. Dr. Gordon noted no coolness or dystrophic changes of the left upper extremity and excellent radial pulse at the wrist. Dr. Gordon diagnosed Petitioner with left wrist and hand symptoms of "unknown etiology". Dr. Gordon discussed sending Petitioner to an "upper extremity specialist" (Dr. Wottowa) but did not restrict Petitioner's work activity. Petitioner was advised to use over-the-counter Ibuprofen or Naproxen as needed. (PX 3)

A Chart Note contained within Dr. Gordon's records and dated April 15, 2014 noted that Michele Frye had contacted Dr. Gordon's office advising that Petitioner's "work comp claim" had been denied and, therefore, the referral to Dr. Wottowa was also denied. A letter from the "TPA" was being sent to Petitioner to advise him of the denial. (PX 3)

On April 23, 2014 Petitioner sought further treatment on his own from Dr. Mark Greatting. Petitioner, who was noted to be right hand dominant, described the work accident of March 1, 2014 to Dr. Greatting who further described it as a hyperextension injury to his left thumb and wrist. Petitioner also summarized the treatment he had up to that point, including Dr. Gordon's treatment. (PX 5) Dr. Greatting noted that Petitioner had been released from care approximately two weeks earlier and told to discontinue his splint and that he could return to work without restrictions but that he should use caution with his left wrist and hand. He was then subsequently released from his employment. Petitioner reported some tingling in the tip of his thumb but no other complaints of numbness or tingling. Dr. Greatting also reviewed Petitioner's x-rays and MRIs noting no abnormalities on the x-rays and some prior to his first visit on April 23, 2014. On examination, Dr. Greatting noted a hesitancy to flex and extend his left wrist as well as decreased flexion/extension of the wrist. Petitioner was tender to palpation around the left wrist/first dorsal compartment thenar area and carpometacarpal joint. Dr. Greatting noted the Petitioner tended to withdraw his hand from fairly light palpation and had "marked pain" with Finkelstein testing. Petitioner's most significantly tender area was the first dorsal compartment. Dr. Greatting also noted pain with palpation of the scaphotrapezial area and carpometacarpal joint with grind testing. Dr. Greatting diagnosed DeQuervain's tenosynovitis and suggested

Petitioner undergo physical therapy and an injection into the first dorsal compartment of his left wrist, which was performed. He was told to stay out of his splint as much as possible. (PX 5)

Petitioner presented to Passavant Hospital for physical therapy beginning on April 28, 2014. Petitioner reported debilitating left non-dominant hand pain. He described his job as a machine operator for Respondent; however, he had been terminated. (PX 8)

Petitioner cancelled his physical therapy appointment of May 5, 2014. (PX 8)

Petitioner returned to see Dr. Greatting on May 29, 2014. Dr. Greatting described Petitioner's pain from their initial visit as diffuse in nature but with some findings suggesting DeQuervain's Tenosynovitis. Petitioner reported that the injection caused increased pain for about three days and then no improvement. On exam the doctor noted some mild diffuse swelling of Petitioner's left hand but he could fully flex and extend his fingers. Petitioner was hesitant to move his thumb and was tender over the first dorsal compartment and significantly tender around the base of his thumb, the radial wrist and his volar wrist area. Petitioner had pain when attempting Finkelstein's test and some decreased flexion and extension of the wrist. Dr. Greatting's office notes record that a discussion was had between doctor and patient regarding the findings on exam which were not entirely consistent with DeQuervain's. Dr. Greatting believed Petitioner's pain related to his exam findings was not specifically localized to that area and appeared excessive for that diagnosis. Additionally, Petitioner's normal x-rays and MRI did not suggest any significant bony or ligamentous injury or problem to explain his pain. Dr. Greatting suspected a possible complex regional pain syndrome, ordered a 3 phase bone scan of the bilateral wrist and hands, and referred Petitioner to Dr. Koteswara Narla for evaluation and management of a possible complex regional pain syndrome. (PX 5)

Petitioner was discharged from therapy on July 8, 2014. The therapist noted that Petitioner was reportedly moaning and grunting when trying to move his thumb and wrist during active range of motion "apparently to indicate pain." This was the same when in the "Game ready." He was holding his hand in a guarded position. (PX 8)

The bone scan was not immediately authorized. Respondent sent Petitioner to Dr. James Williams for a Section 12 Exam. The exam took place on August 13, 2014. Dr. James Williams received a description of both work accidents and Petitioner's work activities and reviewed the medical records generated to that point. In his report Dr. Williams noted that Petitioner had not worked since March 11, 2014 and that he was currently unemployed having put in his two weeks

notice in February to leave and then receiving a call on March 19, 2014 advising him that he no longer had a job. At the time of the examination Petitioner was complaining of both left thumb and wrist symptoms. (RX 6)

On examination, Dr. Williams noted many findings similar to those noted by Dr. Greatting, including: extreme hypersensitivity to light touch over the left dorsal compartment of the left thumb; coldness over the left side; about one third decreased extension and flexion of the wrist when compared to the right wrist; tenderness over the left thumb and radial and dorsal aspects of the wrist; markedly positive Finklestein's test; pain with palpation of the scaphoid trapezial and carpometacarpal joint, and; decreased strength of the left thumb compared to the right.

Dr. Williams was of the opinion that Petitioner's "work accident" caused a complex regional pain syndrome, and aggravated a DeQuervain's Tenosynovitis of the left wrist and hand. Dr. Williams noted that some of Petitioner's responses were exaggerated with inconsistency in grip strength testing, but he, nevertheless, felt that Petitioner's treatment to that point had been reasonable and Petitioner should be evaluated by Dr. Koteswara Narla for complex regional pain syndrome. Dr. Williams did not feel that Petitioner was at maximum medical improvement but he also felt Petitioner could work with restrictions. Dr. Williams noted that Petitioner had a pre-existing diagnosis of DeQuervain's from his February 12, 2013 accident but that Petitioner's current condition included both DeQuervain's Tenosynovitis and complex regional pain syndrome. (PX 6)

Petitioner underwent the three phase bone scan on September 5, 2014 which noted a mild degenerative pattern of radiotracer activity within the carpus on delayed phase according to the report. Nothing suggested RSD. (PX 5)

Petitioner was seen by Dr. Koteswara Narla on September 29, 2014. Petitioner provided Dr. Narla with a history of the work accident and his treatment to that point. Petitioner was wearing his splint to protect his thumb as he reported shooting pain from the base of his thumb and on the dorsal aspect of the thumb tip. He reported improvement in his previous swelling and thumb movement. Dr. Narla noted no color or temperature change, minimal swelling and pain of a six out of ten level. He also noted a very tiny degree of touch allodynia but no hyperalgesia or loss of sensation. (PX 5)

Dr. Narla was unable to conclude that Petitioner had complex regional pain syndrome but he was open to trying some pain medications including the neuropathic adjuvant medications or,

alternatively, Petitioner might wish to see a different pain center. They also discussed sympathetic blocks and use of Amitriptyline. Petitioner was encouraged to do passive and active thumb exercises. Alternatively, the doctor felt Petitioner might have had a soft tissue, ligamentous injury that had persisted for a longer period than normal. Dr. Narla prescribed Petitioner Neurontin, Amitriptyline, and Hydrocodone. (PX 5)

Petitioner was scheduled to return to Dr. Narla in six weeks but, instead, returned to Dr. Greatting on December 4, 2014. On that date Dr. Greatting and Petitioner discussed the bone scan and Dr. Narla's findings. Dr. Greatting examined Petitioner again and noted less sensitivity to light touch than when he first saw him, pain directly over the first dorsal compartment of the left wrist, and a markedly positive Finklestein's test. Dr. Greatting concluded that Petitioner's findings were consistent with DeQuervain's Tenosynovitis and he recommended a release of the left wrist first dorsal compartment although there was no guarantee this would resolve his pain. Dr. Greatting felt there was a good chance of significantly decreasing the Petitioner's pain. (PX 5)

Petitioner's attorney made a demand for TTD benefits through correspondence dated December 4, 2014. (PX 13)

Dr. Voights cleared Petitioner for surgery on January 22, 2015. (PX 11)

Petitioner underwent a left wrist DeQuervain's release on February 6, 2015. (PX 5; PX 9) As of February 18, 2015 Dr. Greatting released Petitioner to light duty work. Petitioner's attorney made a demand for TTD benefits or accommodation of his client's work restrictions through correspondence. (PX 13)As of March 19, 2015 Petitioner was markedly improved over his pre-operative course. Therapy was ordered. A full duty release in one month was anticipated. (PX 5)

Petitioner underwent physical therapy at Passavant Hospital between March 24, 2015 and July 22, 2015. (PX 12)

As of April 27, 2015 Dr. Greatting noted Petitioner was only reporting some intermittent pain. Petitioner felt his strength was significantly decreased but that therapy had helped. On exam Petitioner had good motion of his wrist and hand with no evidence of instability. On Finkelstein's testing he had mild pain. One more month of therapy was ordered, along with ongoing light duty. (PX 5)

Petitioner's attorney wrote to Respondent's attorney by letter dated April 27, 2015 requesting authorization for physical therapy and payment of TTD/accommodation. (PX 13)

Dr. Greatting re-examined Petitioner on June 3, 2015 noting some chronic pain and subjective complaints of weakness but that Petitioner was markedly improved from when he was first examined. His wrist flexion and extension was stable albeit some tenderness was noted. Finkelstein's testing was negative. Dr. Greatting recommended an FCE. (PX 5)

Petitioner's attorney wrote to Respondent's attorney requesting authorization for the FCE and accommodation of his client's restrictions or, alternatively, payment of TTD. (PX 13)

Petitioner underwent his functional capacity evaluation on August 5, 2015. The therapist did not have a formal job description from Respondent to review. Petitioner's description of his job indicated he needed to be able to function in the heavy physical demand level as determined by frequent 45 lb. lifts. After the testing was completed, the therapist noted with regard to Petitioner's consistency and quality of effort – "Subjective complaints of pain during testing were inconsistent with displayed function; Heart rate increases during testing would indicate less than full effort; Absence of changes in body mechanics and quality of motion likely indicate self-limiting effort due to subjective complaints of pain and overguarding; and his pain questionnaire packet responses were expected as compared to observations of functional performance that day." (PX 13) The therapist also noted that Petitioner demonstrated decreased left wrist and hand range of motion and decreased wrist and grip strength. Petitioner also displayed limitation in his ability to maintain left grip strength during all lifts, carrying, and pushing/pulling. The therapist noted that Petitioner's Performance Criteria Profile was consistent with over guarded effort and his level of effort indicated he most likely participated with less than full effort. The therapist also noted that Petitioner's willingness to participate in activity showed marked negative effect on observed functional tolerances. It was therapist's opinion within a reasonable degree of medical certainty that petitioner could perform activity on a full-time basis as follows: (1) Lifting – 14 pounds occasional, and 8 lbs. frequent; (2) Pushing/Pulling – pushing 94.5 lbs. and pulling 129.5 lbs. occasionally; (3) Sitting/Climbing/Crawling – Occasional; (4) Reaching/Bending/Squatting/Crawling – Frequent; and (5) Walking – Constant. (PX 10)

Dr. Greatting released Petitioner on October 14, 2015 subject to the permanent restrictions outlined by the therapist in the FCE. He was deemed at maximum medical improvement and told to return if necessary. (PX 5)

By letter dated October 16, 2015 Petitioner's attorney requested accommodation of the permanent restrictions or appropriate benefits and vocational rehabilitation. (PX 13)

Petitioner's case herein proceeded to arbitration on November 18, 2016. At that time both of Petitioner's cases against Respondent (14 WC 10935 and 14 WC 10769) were heard with the understanding that separate decisions would be issued. Michelle Frye was present as Respondent's representative. Two witnesses testified at the hearing: Petitioner and Scott Honnen.

Petitioner testified that he was employed as a machine operator on February 12, 2013 and had been so employed at the Respondent's facility for over one year on a full- time basis. Prior to that Petitioner had worked for Respondent through a temporary agency for one year.

Petitioner testified that on February 12, 2013 he was operating a machine and thought he heard a co-employee call to him. Because of the noise of the machines he was not certain if someone called him. Petitioner turned to see who was speaking to him and struck the inside of his left wrist just below his thumb on the corner of a safety pole. Petitioner testified that it felt like a "stoved toe" but he didn't think much about it.

Petitioner stated that prior to this accident he had not had any problems with his left hand, arm or thumb.

Petitioner testified that he began noticing a loss of strength in his hand after the accident. He went to Passavant Hospital on March 2, 2013 where he was given a splint and told to stay off work for two days.

Petitioner testified that he advised his supervisor about the situation and gave him his off work slip on the Monday following March 2, 2013 as that was the day Petitioner was told to go to Midwest Occupational Health Associates (MOHA). (PX 3) Petitioner testified that he was treated by Dr. Gordon who allowed him to work but continued to monitor him. During this time Petitioner continued to experience pain. Petitioner also testified regarding the care provided to him by Dr. Allan which testimony was consistent with the doctor's medical records.

Petitioner also testified that he underwent a thumb and wrist MRI on July 18, 2013 per Dr. Gordon and thereafter Dr. Gordon declined to further treat Petitioner; however, he told Petitioner that he needed diagnostic testing and imposed no work restrictions. Petitioner testified that despite all that, he was no better. Petitioner further testified that Dr. Gordon discharged him on July 31, 2013 and he sought no further medical care until March 1, 2014 when he was involved in another work accident.

Petitioner testified that while he sought no further treatment after July 31, 2013 he remained symptomatic as he noticed left wrist weakness, limited mobility, a sharp stabbing pain and, on occasion, a tingling sensation in his thumb and wrist area. He continued working full capacity as an operator.

Petitioner testified that on March 1, 2014 he was in another accident while walking a pallet filled with shrink wrapped product (and weighing about 600 lbs.) down an aisle using his right hand to pull the pallet behind him. As he did so another worker pulled another pallet in front of him and let it go right in front of Petitioner so he turned to place both hands on the handle of his pallet to stop it when his left hand slipped off the hand, caught his thumb and bent it back towards his wrist. Petitioner testified to immediately feeling a pop in his hand and wrist followed by pain and throbbing. He told his supervisor immediately but continued working and finished his shift; however, while doing so his complaints worsened and he began to feel a stabbing, slight burning sensation also.

Petitioner testified that he was again sent to Dr. Gordon and he also saw the company nurse. He described swelling in his entire hand and wrist. Petitioner felt the 2014 accident caused the same symptoms as the 2013 accident except for more pain complaints.

Petitioner acknowledged telling Dr. Gordon and the others that he was taking Prednisone for a non-work-related foot problem. He also testified that Dr. Gordon prescribed more Prednisone and had x-rays taken, ultimately releasing him back to full duty. Dr. Gordon also scheduled an MRI.

Petitioner testified that the day after the accident he was put back to work running machines but told his supervisor that he couldn't keep doing that job because he would immediately notice throbbing, severe pain in his hand and wrist when he lifted it or when he tried to hold anything. Petitioner testified to loss of strength in his left hand. He was then moved from being an operator to that of a reliever which meant he went around and filled in for people while on breaks or at lunch. He tried doing relief work for a while but was unable to do it so he was transferred to "rework" where he would open boxes, remove product, and set it aside for "rework" to rerun or fix it.

Petitioner testified to undergoing the MRI. He also testified that "around that time" he separated from his employment with Respondent. He thought it was around March 18, 2014. Petitioner testified that he was thinking of leaving his job with Respondent because he and his

family were having some financial problems and it was getting very hard for them to manage their home. Petitioner also testified that his family was already thinking about moving back to Pennsylvania to be closer to family due to child care issues and he and his wife's schedules. Although terminated from his job with Respondent, Petitioner continued to treat with Dr. Gordon.

According to Petitioner he saw Dr. Gordon on March 24, 2014 at which time the doctor told him that he couldn't offer any further treatment to him, despite his ongoing symptoms. When the doctor examined him on April 7th, he prescribed more Prednisone but still let him work full duty. Their last visit was on April 14, 2014.

Petitioner testified that he began treating with Dr. Greatting on April 23, 2014 and he told him about his 2014 accident and the treatment he had received for it. He also described his symptoms. Dr. Greatting imposed no restrictions at their first visit but did give him an injection. This was followed by a second one and neither one provided any relief.

Petitioner further testified that he returned to see Dr. Greatting on May 29, 2014 at which point the doctor told him he might have reflex sympathetic dystrophy. Petitioner then saw Dr. Narla and underwent a bone scan both of which were authorized by workers' compensation. Dr. Narla prescribed Neurontin and Amitriptyline, the latter being prescribed to help with sleep issues attributable to problems with his thumb/wrist.

Petitioner acknowledged seeing Dr. Williams at the request of Respondent in August of 2014 and that the doctor performed a very thorough exam.

Petitioner testified that he returned to see Dr. Greatting on December 4, 2014 due to ongoing symptoms at which point the doctor suggested he undergo a DeQuervain's release and imposed restrictions. Petitioner proceeded with surgery on February 6, 2015 which was paid for by his wife's insurance carrier. After surgery, Dr. Greatting released him to light duty and prescribed physical therapy which he did at Passavant Hospital. According to Petitioner as of April 27, 2015 he had improved range of motion but not strength. His level of pain had gone down to a 5-6 and changed from feeling like you had a "9 volt battery stuck to your tongue" to a dull ache. Dr. Greatting ordered a functional capacity evaluation that was performed on August 5, 2015. Thereafter, he imposed permanent restrictions of no lifting over 4 pounds occasionally, 8 lbs. frequently, and some other things.

Petitioner testified that he tried several times to contact Respondent about returning to work but he received no response. He looked for work on his own but did not document his job search. Petitioner moved back to Pennsylvania on April 2, 2016. He remains unemployed. He never asked Respondent for help in finding a job.

Petitioner testified that he has reduced range of motion, pain that fluctuates from day to day and with the weather and activities. He had been a volunteer firefighter for seventeen years but can no longer do that. He cannot work in EMS anymore because he cannot lift anyone or carry a stretcher. Petitioner testified that if he tries to lift things with his left hand and arm he drops them. His five year old son has to help him cook dinner and his wife has to assist him opening jars. On occasion she has to cut his meals for him because he cannot hold a knife. Petitioner also testified to problems with his grip and his thumb. When he tries to squeeze or bend his wrist certain ways it becomes more painful. Petitioner testified that he has to alter the way he uses his hand to avoid symptoms. Petitioner acknowledged that he can make a fist. Petitioner is right handed.

On cross-examination Petitioner testified that he always told his doctors the truth about his complaints and how he was doing. He agreed that after the first accident he saw Dr. Gordon and one other doctor, missed no time from work and was able to perform all of his job duties for Respondent when he was released by Dr. Gordon in 2013 albeit with some difficulties. Petitioner acknowledged that July 31, 2013 was the last time he sought any medical care for the first accident and at that point he was released to full duty which he performed through March 7, 2014.

Petitioner testified that he had a second accident on March 1, 2014. He agreed that Respondent worked with him to find easier jobs. Petitioner was unaware of any light duty program by Respondent.

Petitioner also acknowledged having conversations with someone from Respondent regarding separating his employment with Respondent. He also acknowledged mentioning to individuals that he was going to leave the State for financial reasons. He also agreed that Respondent knew he was considering leaving his position with it and that he was informed that it had considered him as having resigned his position adding that he voiced his opinion that he was considering leaving but not that he was actually physically doing that. He also agreed that earlier in the year 2016 he did leave the State for financial reasons. Petitioner testified that "they" called

him on March 18, 2014 at 8 a.m. to let him know that he no longer worked for Respondent and then around 9:30 a.m. he got a call from the medical staff telling him they had received his MRI and that it showed he had arthritis in his left wrist but was, otherwise, normal. He also agreed that Dr. Gordon last saw him in April of 2014.

Petitioner testified that he went to Dr. Greatting because other people, and not his attorney, had recommended him. Petitioner acknowledged the functional capacity evaluation. When asked if he remembered a notation about submaximal effort being given Petitioner replied "No." and added that from his review of the report he had given ample participation in the evaluation. Petitioner also testified that at that time he would try to help run the sweeper at home, feed the dogs, and help bathe his son and do other daily activities. He agreed that lifting bothered his wrist and carrying objects bothered his wrist.

Petitioner could not recall the dates of any conversations with Respondent regarding attempts to go back to work although they would have been in 2014. He denied being employed in any capacity since his separation with Respondent.

Scott Honnen testified on behalf of Respondent. He has worked for Respondent for 27 years, the last ten of which have been as a unit manager on the manufacturing side of the business. Mr. Honnen testified that Respondent has a light duty program which involves trying to find work for injured employees who have restrictions.

Mr. Honnen testified to knowing Petitioner through his employment with Respondent. It was his understanding that Petitioner resigned because he was moving out of state. If Petitioner had light duty restrictions after March of 2014 Respondent would have considered him for a light duty job.

On cross-examination Mr. Honnen testified that he didn't know if Petitioner was ever sent a termination letter. He agreed that he had never spoken directly with Petitioner about his employment status. He never saw a resignation letter from Petitioner but that, in some cases, there are such letters. He did not know anything about Petitioner's application for unemployment.

Petitioner was called on rebuttal and testified that he applied for unemployment after he was terminated but it was denied. He received a document stating he was unable to work due to a medical condition. He also agreed that no one from Respondent ever contacted him offering him light duty.

The Arbitrator concludes:

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

Petitioner's current condition of ill-being in his left wrist, hand, and thumb is causally related to his March 1, 2014 accident. In so concluding the Arbitrator relies upon the opinions of Dr. Williams (Respondent's examining physician), the records of Dr. Greatting, and a chain of events.

While Respondent may suggest that Petitioner reached maximum medical improvement on April 7, 2014, the Arbitrator disagrees. Dr. Gordon did not find Petitioner to be at maximum medical improvement at that time nor did he release Petitioner from his care. Petitioner returned to see Dr. Gordon on April 14, 2014 and the doctor acknowledged he had been treating him for a work-related injury. On examination Petitioner had tenderness to palpation, edema of the left hand and diminished range of motion. Dr. Gordon did not release Petitioner; rather, he discussed sending him to a specialist. Petitioner was still on medication at that time and the only reason Petitioner was not referred to Dr. Wottowa as Dr. Gordon desired was because Michele Frye (who was present at the arbitration hearing but did not testify) had contacted him and told him Petitioner's workers' compensation claim was being denied. Petitioner, quite reasonably and understandably, sought out further care on his own and through an upper extremity specialist.

Dr. Williams, Respondent's examining physician, evaluated Petitioner on August 13, 2014. Dr. Williams took no issue with Petitioner's treatment and found his work accident caused a complex regional pain syndrome and aggravated Petitioner's DeQuervain's Tenosynovitis. He agreed with the referral to Dr. Narla regarding the complex regional pain syndrome. While a diagnosis of complex regional pain syndrome was ruled out, the diagnosis of DeQuervain's Tenosynovitis remained and required surgical intervention. Respondent offered no evidence that Petitioner sustained an injury to his left hand or thumb between his accident in case number 14 WC 10769 (February 12, 2013) and the accident of March 1, 2014, nor did Respondent offer any evidence of any non-work related injuries which might account for Petitioner's recurrent and worse left hand, thumb and wrist condition after the accident of March 1, 2014.

Based on a chain of events and the opinions and records of Dr. Greatting and Dr. James Williams, the Arbitrator finds that Petitioner has carried his burden of proving that his work

accident of March 1, 2014 caused an aggravation of his pre-existing DeQuervain's Tenosynovitis and a left hand pain syndrome.

Issue (J)Were the medical services that were provided to Petitioner reasonable and necessary?:

Petitioner is awarded the following medical bills found in PX 6 as the Arbitrator finds them to be reasonable, necessary and causally related to the accident:

Springfield Clinic, 3/18/14-10/14/15	$ 5,505.04
Memorial Medical Center, 2/6/15	$ 6,693.65
Apex Physical Therapy, 8/5/15	$ 1,327.84
Passavant Area Hospital, 4/28/14-4/30/14	$ 922.89
Passavant Area Hospital, 5/2/14-5/9/14	$ 711.72
JCH Medical Group, 1/22/15	$ 95.00
Passavant Area Hospital, 3/24/15-3/27/15	$ 985.50
Passavant Area Hospital, 3/30/15-4/3/15	$ 890.40
Passavant Area Hospital, 4/6/15-4/10/15	$ 1,051.97
Passavant Area Hospital, 4/13/15-4/17/15	$ 1,038.80
Passavant Area Hospital, 5/1/15	$ 296.80
Passavant Area Hospital, 5/4/15-5/8/15	$ 890.40
Passavant Area Hospital, 5/11/15-5/15/15	$ 890.40
Passavant Area Hospital, 5/18/15-5/22/15	$ 890.40
Passavant Area Hospital, 5/27/15-5/29/15	$ 593.60
Total:	**$22,784.41**

Said bills are awarded pursuant to the Medical Fee Schedule. Respondent shall receive credit for any bills previously paid.

Issue (K) Temporary Total Disability (TTD) Benefits.

Petitioner is awarded temporary total disability benefits from August 13, 2014 through October 14, 2015, a period of 62 3/7 weeks.

The parties agree that Petitioner ceased to be employed by Respondent in March of 2014. However, exactly why that occurred is debated. Respondent contends Petitioner may have voluntarily resigned and Petitioner contends he was terminated. According to information provided by Petitioner to Dr. Williams in August of 2014 Petitioner gave Respondent notice of his intent to quit in February of 2014, stopped working on March 11, 2014, and was told on March 19, 2014 that he no longer had a job with Respondent. Exactly why Respondent advised Petitioner he no longer had a job with it as of March 19, 2014 was never directly addressed by

Respondent and could have been, especially if Petitioner had, indeed, voluntarily left his job as Respondent seems to be suggesting. Having failed to do so, it appears that Petitioner was terminated from his employment. While within its rights to do so, its obligation for payment of TTD benefits did not end. Dr. Williams examined Petitioner on August 14, 2014 and imposed work restrictions which could not be accommodated given the fact Petitioner was no longer employed by Respondent. Dr. Greatting released Petitioner to return to work as of October 14, 2015 with permanent restrictions having reached maximum medical improvement.

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

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).

With regard to the five factors and Petitioner's case, the Arbitrator notes:

(i) Neither party submitted a rating pursuant to Section 8.1(a).

(ii)Occupation: Petitioner was employed as an operator for Respondent at the time of his accident. As a result of his work-related injury he has permanent restrictions that keep him from returning to work as an operator. Petitioner testified that he remains unemployed since his separation with Respondent and while he has engaged in a job search, he had no documentation for it. Petitioner further testified that he has been unable to resume his work as a volunteer firefighter or EMS person due to his injury as he cannot lift in the manner required by both positions. This factor is given significant weight.

(iii)Age: Petitioner was 37 years old at the time of his accident. 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. Petitioner is currently unemployed. His restrictions preclude many occupations. While Petitioner has looked for work, his efforts have not been documented. Therefore, it is unknown how many jobs or what types of jobs Petitioner has attempted to secure and the extent to which his earning capacity has truly been affected.

(v)Disability: When examined by Dr. Greatting on June 3, 2015 Petitioner complained of some chronic pain and weakness but he was noted to be markedly improved since the time of his first examination. He had undergone a DeQuervain's release and, on examination, he had stable wrist flexion and extension with some tenderness. Finkelstein's testing was negative. Dr. Greatting ordered an FCE and that was performed on August 5, 2015. Petitioner was

deemed unable to return to work as an operator, permanent restrictions were suggested, and the therapist expressed concerns about the validity of Petitioner's efforts during the exam. Petitioner followed up with Dr. Greatting who imposed permanent restrictions and released him. No other findings were noted at that time.

The Arbitrator had some concerns about Petitioner's credibility regarding his ongoing symptoms and job search efforts. The former was troublesome given the fact doctors, and the therapist, routinely noted his symptoms and complaints were inconsistent with his objective examination. Furthermore, Petitioner incorrectly testified regarding the physical restrictions imposed upon him. He was not limited to no lifting over four pounds occasionally; rather, it was 14 pounds. The validity of his job search efforts was troublesome as he had no proof to substantiate them.

At the arbitration hearing Petitioner testified to improvement in his condition since his surgery but ongoing problems with pain, weakness, grip strength, and limitations. The Arbitrator has considered Petitioner's testimony in light of the FCE, the therapist's and doctors' comments regarding Petitioner's complaints, and her own concerns regarding Petitioner's overall credibility regarding the extent of his disability, concluding that Petitioner does have some ongoing chronic pain and weakness in his non-dominant left hand and he is unable to return to work as an operator. She further notes that Respondent did not have Petitioner re-examined by a doctor nor did it obtain an impairment rating.

Having considered the foregoing factors, the Arbitrator concludes that Petitioner is now permanently partially disabled to the extent of 30% loss of use of a man as a whole pursuant to Section 8(d)2 of the Act.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kathy Westerman,

Petitioner,

vs. NO: 13 WC 13449

State of Illinois - Menard Correctional Center,

18IWCC0372

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, 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 March 8, 2017, is hereby affirmed and adopted.

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

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

DATED: JUN 12 2018
TJT:yl
o 6/4/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WESTERMAN, KATHY
Employee/Petitioner

Case# **13WC013449**

STATE OF ILLINOIS/MENARD C C
Employer/Respondent

18IWCC0372

On 3/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4075 FISHER KERKHOVER COFFEY
JASON E COFFEY
1300 1/2 SWANWICK ST SUITE 203
CHESTER, IL 62233

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

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 106
CARBONDALE, IL 62901

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

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

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

MAR 8 - 2017

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

18IWCC0372

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

Kahty Westerman
Employee/Petitioner

v.

State of IL/Menard C.C.
Employer/Respondent

Case # 13 WC 13449

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 William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on February 15, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18 IWCC0372

FINDINGS

On March 22, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $48,428.12; the average weekly wage was $931.31.

On the date of accident, Petitioner was 53 years of age, single with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 5, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for benefits which 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 $558.79 per week for 41 weeks because the injury sustained caused the 10% loss of use of the right hand and the 10% loss of use of the left hand, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher

William R. Gallagher, Arbitrator
ICArbDec p. 2

March 4, 2017
Date

MAR 8 - 2017

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of March 22, 2011, and that Petitioner sustained repetitive trauma to her right and left hands and arms (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1).

Petitioner testified she started working for Respondent in 1991. For the first four years, Petitioner worked for Respondent as an independent contractor; however, afterward she became an employee of Respondent. For the entire time Petitioner worked for Respondent, she performed clerical/office work which included filing, typing, handwriting, etc. Petitioner retired after working for Respondent for approximately 24 years. Petitioner's last day of work for Respondent was May 31, 2015.

During the time Petitioner worked for Respondent, she had various job assignments in different departments; however, Petitioner always performed clerical/office tasks. At trial, Petitioner tendered into evidence a sheet of paper which briefly described where she worked and a brief description of the duties she performed. The earliest time indicated on the sheet was July, 1991, and went through the present. The date the sheet was prepared was not stated; however, it appeared as though Petitioner prepared it sometime prior to her retirement in May, 2015. For the entire time Petitioner worked for Respondent, she used either a keyboard or typewriter. It also stated that, for approximately 16 years, Petitioner typed with her arms elevated up to the top of a desk to reach the keyboard and that the position was uncomfortable (Petitioner's Exhibit 1).

At trial, Petitioner testified she spent approximately six hours of her seven and one-half hour workday typing/keyboarding a wide variety of documents. These documents included memos, evaluations, data for the offender tracking system, etc. Petitioner also performed other clerical tasks which required the active use of her hands which included pulling files, handwriting time records, etc. Petitioner stated she used both upper extremities all day long. Petitioner said her fingers would get numb when she typed. She also said that when the keyboard was lowered to a tray underneath the desk that it relieved some of her hand symptoms.

Petitioner initially sought medical treatment on February 28, 2011, from Dr. James Krieg, her family physician. At that time, Petitioner complained of parasthesias of her hands and fingers. There was no reference to Petitioner's work activities. Dr. Krieg ordered EMG/nerve conduction studies to be performed on March 22, 2011 (Petitioner's Exhibit 2).

On March 22, 2011 (the date of manifestation alleged in the Application), Petitioner was seen by Dr. James Goldring, who performed EMG/nerve conduction studies. Dr. Goldring opined the studies were positive for bilateral carpal tunnel syndrome; however, he noted that the findings on the left hand were borderline. In his letter dated March 22, 2011, to Dr. Krieg, Dr. Goldring stated that Petitioner related "...a longstanding but intermittent history of numbness and tingling in her hands. This is notable when she is using them, for example doing keyboard work or using her hands overhead." (Petitioner's Exhibit 3).

Petitioner was subsequently seen by Dr. Krieg on April 28, 2011. At that time, Dr. Krieg reviewed the nerve conduction studies and discussed treatment options with Petitioner, including the continued use of night wrist splints (Petitioner's Exhibit 2).

At trial, Petitioner testified that on March 22, 2011, she was informed she had carpal tunnel syndrome. Petitioner subsequently completed and signed a "Employee's Notice of Injury" form on May 2, 2011. The form stated Petitioner had sustained a work-related injury as a result of "keyboarding, typing, writing reports" that caused bilateral carpal tunnel syndrome. The following day, May 3, 2011, a "Supervisor's Report of Injury or Illness" was prepared by Shannie Stock, Assistant Warden (Petitioner's Exhibit 6).

Petitioner subsequently sought treatment from Dr. Harvey Mirly, an orthopedic/hand surgeon, on April 5, 2013. Dr. Mirly noted that Petitioner was employed doing "clerical work" and was pursuing her case through workers' compensation. He did not describe any of the specifics of Petitioner's work duties. Dr. Mirly opined Petitioner had bilateral carpal tunnel syndrome. He discussed treatment options with Petitioner including surgery. At that time, Petitioner decided not to proceed with further treatment unless her symptoms worsened (Petitioner's Exhibit 4; Deposition Exhibit 2).

Petitioner continued to work; however, her hand symptoms worsened and she was again seen by Dr. Mirly on September 20, 2013. Dr. Mirly's record of that date noted Petitioner's hands would go numb while holding a phone while typing. Because of Petitioner's persistent symptoms, Dr. Mirly recommended Petitioner proceed with carpal tunnel surgery on both hands (Petitioner's Exhibit 4; Deposition Exhibit 2).

Dr. Mirly performed right and left carpal tunnel release surgeries on November 15, 2013, and January 10, 2014, respectively. Petitioner recovered from the surgeries and was discharged from care by Dr. Mirly on January 24, 2014 (Petitioner's Exhibit 4; Deposition Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Anthony Sudekum, a plastic/hand surgeon on October 30, 2014. In connection with his examination of Petitioner, Dr. Sudekum reviewed medical records and information regarding Petitioner's job duties provided to him by Respondent. Dr. Sudekum opined that, based upon the nerve conduction studies, Petitioner had mild right carpal tunnel syndrome, but the test did not reveal any evidence of left carpal tunnel syndrome. Dr. Sudekum opined Petitioner had evidence of mild arthritic changes in the left hand at the CMC joint. In regard to causality, Dr. Sudekum opined Petitioner's work activities did not cause or contribute to any injury to either upper extremity. Dr. Sudekum noted Petitioner had significant not work-related risk factors which could have caused, contributed to or predisposed Petitioner to develop carpal tunnel syndrome including being female, her age, long history of smoking, osteoarthritis of the hand/wrist and her hobby of doing crafts (Respondent's Exhibit 2).

Dr. Sudekum was deposed on June 9, 2015, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Sudekum's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to the diagnosis of bilateral carpal tunnel syndrome, Dr. Sudekum opined the nerve conduction studies performed

were "virtually normal" with only "borderline values." In regard to causality, Dr. Sudekum testified Petitioner's upper extremity conditions were not caused, aggravated or exacerbated by her work activities. He referenced Petitioner's other risk factors, in particular, Petitioner's age and smoking. Dr. Sudekum also based his opinion, in part, on medical literature and journal articles which he stated found no significant connection between typing/keyboarding and the development of carpal tunnel syndrome (Respondent's Exhibit 3; pp 16, 20-23).

On cross-examination, Dr. Sudekum agreed he had no knowledge about the details of Petitioner's "crafting" activities and could not rule them in or out of whether they were a factor in the development of Petitioner's upper extremity symptoms. He also agreed it was possible for individuals to have multiple risk factors, both occupational and non-occupational, which could lead to the development of carpal tunnel syndrome (Respondent's Exhibit 3; pp 34, 42-43).

On June 2, 2016, Petitioner's counsel wrote Dr. Mirly and provided him with information regarding Petitioner's work duties as well as a copy of Dr. Sudekum's medical report. He requested Dr. Mirly provide him with an opinion regarding causality. Dr. Mirly prepared a report dated June 14, 2016, which was received into evidence at trial. Dr. Mirly opined the cause of carpal tunnel syndrome was multifactorial and could be influenced by non-occupational factors. He referenced Petitioner being female, over 56 years of age, history of smoking, osteoarthritis and craft hobbies. However, Dr. Mirly also noted Petitioner did not have either diabetes or hypothyroidism. In regard to Petitioner's work activities of keyboarding, pulling files and handwriting, he opined that these were not the sole cause of Petitioner's carpal tunnel syndrome, but would be contributing factors to its development (Petitioner's Exhibit 4; Deposition Exhibit 3).

Dr. Mirly was deposed on December 9, 2016, and his deposition testimony was received into evidence at trial. In regard to his treatment of Petitioner's bilateral carpal tunnel syndrome, his testimony was consistent with his medical records. When questioned about causality, Dr. Mirly testified Petitioner's work activities would have been contributing factors to the development of Petitioner's bilateral carpal tunnel syndrome, but not "solely causative." He specifically noted Petitioner had engaged in the repetitive work activities for approximately 24 years (Petitioner's Exhibit 4; pp 17-20).

On cross-examination, Dr. Mirly agreed Petitioner's history of smoking would have been a contributing factor. He also agreed he had not reviewed the data regarding Petitioner's job duties until June, 2016, shortly before he prepared his narrative report (Petitioner's Exhibit 4; pp 24-25, 31-32).

At trial, Petitioner stated she had been a smoker since she was 14 years old and smoked one pack of cigarettes per day. Petitioner stated her symptoms improved following surgery, but she still has complaints of pain in both the right and left hands. Petitioner stated she still experienced difficulties from some household tasks which included opening jars and various kitchen duties. She also stated she has difficulties and experiences pain when lifting items above waist level because of her hand symptoms.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner sustained a repetitive trauma injury that arose out of and in the course of her employment for Respondent that manifested itself on March 22, 2011.

In support of this conclusion the Arbitrator notes the following:

Petitioner was initially diagnosed with bilateral carpal tunnel syndrome on March 22, 2011, when she had EMG/nerve conduction studies performed.

Petitioner's testimony regarding the facts of her job duties and that they required the repetitive use of both hands over a period of 24 years was unrebutted.

When Petitioner underwent the EMG/nerve conduction studies on March 22, 2011, she informed Dr. Goldring she experienced numbness and tingling while keyboarding.

Petitioner informed Dr. Mirly, her primary treating physician, she performed clerical work and her hands would become numb when holding a phone while typing.

Dr. Mirly did not provide an opinion regarding causality until he was requested to do so by Petitioner's counsel when he was provided with information regarding Petitioner's job duties. Dr. Mirly agreed the etiology of Petitioner's carpal tunnel syndrome condition was "multifactorial" but that Petitioner's work activities were contributing factors.

Dr. Sudekum, Respondent's Section 12 examiner, opined Petitioner's work activities did not cause or contribute to her bilateral upper extremity condition and also questioned the diagnosis of bilateral carpal tunnel syndrome. He based his opinion upon Petitioner's other risk factors and his review of medical literature. The medical literature Dr. Sudekum relied upon was not specifically identified.

Dr. Sudekum had no knowledge about Petitioner's "crafting" and could not opine whether it was or was not a factor. Further, Dr. Sudekum agreed it was possible for an individual to have multiple risk factors, both occupational and non-occupational, which could cause carpal tunnel syndrome.

The Arbitrator finds the opinion of Dr. Mirly to be more persuasive than that of Dr. Sudekum. Dr. Mirly and Dr. Sudekum agreed that the carpal tunnel syndrome can be caused by multiple risk factors or, as Dr. Mirly stated "multifactorial." Dr. Sudekum's opinion that Petitioner's work activity was not one of those factors was based, in part, on "medical literature" which was not identified when he was deposed.

The fact that Dr. Mirly did not opine as to the causality until he received information regarding Petitioner's job activities enhances his credibility. Dr. Mirly did not opine whether Petitioner's condition was work-related based upon the limited information that he initially received from Petitioner that she did "clerical work."

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

The Arbitrator concludes that Petitioner gave notice to Respondent within the time required by the Act.

In support of this conclusion the Arbitrator notes the following:

It was undisputed Petitioner completed a report of injury on May 2, 2011. That was within the time limit prescribed by the Act.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 5, as provided in Sections 8(a) and 8.2 of Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for benefits which 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 Act.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 10% loss of use of the right hand and 10% loss of use of the left hand.

In support of this conclusion the Arbitrator notes the following:

Petitioner was diagnosed with bilateral carpal tunnel syndrome and underwent corrective surgery on both hands.

Petitioner recovered from the surgeries and was able to return to work to her regular job.

Petitioner still has some complaints of pain and weakness in both hands consistent with the injury she sustained. However, Petitioner is presently retired and is no longer using her hands in the same repetitive manner she was while working for Respondent.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gloria McGlasson,

Petitioner,

vs. NO: 15 WC 35096

State of Illinois, Alton Mental Health Center,

18IWCC0373

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 8, 2017 is hereby affirmed and adopted.

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

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

DATED: JUN 12 2018
TJT:yl
o 6/4/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McGLASSON, GLORIA
Employee/Petitioner

Case# **15WC035096**

SOI/ALTON MENTAL HEALTH CENTER
Employer/Respondent

18IWCC0373

On 5/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.97% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1539 DRUMMOND LAW OFFICE
PETER C DRUMMOND
703 W UNION SUITE 3 PO BOX 130
LITCHFIELD, IL 62056

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

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

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

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

MAY 8 - 2017

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

18IWCC0373

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

GLORIA MCGLASSON
Employee/Petitioner

v.

STATE OF ILLINOIS/ALTON MENTAL HEALTH CENTER
Employer/Respondent

Case # **15** WC **35096**

Consolidated cases: _____

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

DISPUTED ISSUES

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

FINDINGS

On **Septemer 14, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$88,848.00**; the average weekly wage was **$1,708.62**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **$ANY AND ALL PAID** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision, Petitioner sustained an accident which arose out of and in the course of her employment with Respondent on September 14, 2015. Petitioner's current condition of ill-being with regard to her left shoulder and arm is related to the accident.

Respondent shall pay reasonable and necessary medical services totaling $32,651.50, as reflected in Petitioner's Exhibit 6 that remain unpaid. Specifically, Respondent shall pay the following bills, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act: Washington University Physicians $14,056.00 and Apex Network Physical Therapy $18,595.50. Respondent shall receive credit for amounts paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving credit under Section 8(j).

Respondent shall pay Petitioner the sum of **$755.22/week** for a further period of **125 weeks**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused a **25% loss of use of the person as a whole**.

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

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

Signature of Arbitrator

May 4, 2017
Date

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

18IWCC0373

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GLORIA MCGLASSON
Employee/Petitioner

v.

Case #: 15 WC 35096

STATE OF ILLINOIS/ALTON MENTAL HEALTH CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On September 14, 2015, Petitioner was 58 years of age, married, and had no dependent children. The parties stipulated that on that date Petitioner sustained a fall on the sidewalk in front of Respondent's building where she worked and that she sustained injury to her left arm and shoulder. Respondent disputed that Petitioner's accident arose out of and in the course of her employment, but agreed that the injuries sustained were as a result of that fall.

Petitioner testified she is a Social Worker for the Department of Human Services at Alton Mental Health Center and has been so employed for more than 25 years. Her job duties include one-on-one contact with clients, developing treatment plans, writing progress reports on the treatment plan, counseling clients, and discharge planning. Approximately half of her time is spent in direct contact with clients. The Alton Mental Health Center has two divisions, a civil psychiatric unit and a forensic psychiatric unit. Petitioner works in the forensic unit, which provides treatment for adult patients who have been committed through the criminal court because they are unfit to stand trial or have been found not guilty by reason of insanity.

Petitioner testified that on September 14, 2015, she was leaving work after her normal shift at approximately 4:30 p.m. when she "stepped off the sidewalk", causing her to fall and break her left arm and shoulder. As she was walking she heard a patient that was off grounds on a pass and he asked her if there had been any progress on paperwork that Petitioner had been working on for him. As he was behind her, she turned her head to answer him and as she went forward she fell on the sidewalk in front of the building.

Petitioner identified a group of nine photographs, marked as Petitioner's Exhibits 5(a) through 5(i), as photos of the grounds and buildings of the Alton Mental Health Center which depict the entrances, grounds, parking areas, and posted signs prohibiting public entry. Her attorney took the photos after she informed onsite security he would be there. Exhibit 5(a) was a

photograph of the front entrance of the facility and 5(b) was a directional sign that directed people which road to take to a certain building, including the forensic building and security for the facility. Exhibit 5(c) was taken at the back gate, on the north side of the facility, and exhibit 5(d) was taken at the main gate on the south side. Both photos show a sign stating, "No admittance without proper identification and authorization. Violators will be subject to arrest for trespassing on State land." Petitioner testified that the facility is secure and that you must be authorized to be on the grounds. People so authorized include patients, staff, visitors, law enforcement, contractors, and the like. Exhibit 5(e) was a large photograph taken by Petitioner and her husband in the area where she fell. It shows the sidewalk, a piece of board, and a ruler, and depicts that the ground was about two inches lower than the sidewalk where she fell. The photo does not show grass, but Petitioner testified that there was grass present when she fell in September. Exhibits 5(f) and 5(i) showed signs indicating that law enforcement personnel had to leave all weapons in their vehicles and that no firearms were permitted at the facility.

Exhibit 5(g) was a view of the forensic facility from the parking area, looking at the entrance of the building. It showed the sidewalk that goes from the parking lot to the front of the building and depicts that the sidewalk splits to the right and left. Petitioner marked an "X" where she fell. Exhibit 5(h) was an aerial photo of the Alton Forensic Center and the parking lot, and also shows a fence around the building and yard. Petitioner marked an "X" where she fell. The Arbitrator notes the spot she marked on both photos was located where the sidewalk splits or bends to the left. The Arbitrator further notes the sidewalk in question is not within the fenced area of the facility and yard.

Petitioner testified that on the date of accident she turned back to look at the patient talking to her and she "just lost my balance and then I just fell". She landed on the concrete on her shoulder and was in a lot of pain. Staff came out to assist, an ambulance was called, and she was taken to the hospital. She had surgery a week later to insert a rod and several pins into the ball and socket of her arm. Following surgery she underwent about four months of physical therapy. She returned to work light duty on December 14, 2015, and released for full duty in April 2016. She continues to work full duty at the facility.

Petitioner testified she continues to have stiffness, pain, lack of mobility, and lack of strength. She cannot raise her arm much above her shoulder. She has difficulty with daily activities such as taking clothes out of the dryer, getting things on and off a shelf, putting on her bra, pulling her pants up, hanging clothes, using an ATM, reaching for food in a drive-thru, lifting heavy bags, and the like. She testified she does many of these activities one-handed now, due to the problems with her left arm and shoulder.

Petitioner testified she was eligible to retire and would be retiring on the Wednesday following her hearing. She testified she could have worked a little bit longer but could no longer do some of the behavior intervention and thought it best to avoid the risk and retire. The patients frequently show aggression and she would have to be able to block a hit and/or contain patients if they were attacking someone else. This happens on a weekly basis. She did not believe she had the strength or mobility to do so.

Petitioner opined that the sidewalk was a factor in her fall for two reasons. First, the dirt ground was lower than the sidewalk. Second, the sidewalk curves around and goes from a wide area to a narrow area. She had previously stepped off the sidewalk unintentionally and had witnessed others do so as well.

On cross-examination, Petitioner testified she does not take any prescription medication but does take Aleve. She acknowledged she had been released to work full duty and had been so working since April 2016. She testified she typically entered and exited the building by the same path, which was the sidewalk to the left side after the sidewalk splits. On the day of the accident she gathered her belongings, went through a room in the main hall of the building, signed out, went to the control center in the front of the building, went through the two locked doors, and exited the building. She left around 4:30, was not in a hurry to get anywhere, and was carrying her purse and a cup. She testified the sidewalk was cracked in spots but she did not believe there was anything about those cracks that caused her to fall.

Petitioner did not particularly remember witness Margaret Harris approaching her after the fall. Ms. Harris gave a statement and indicated that Petitioner said her foot slipped off the concrete walk into the grass area which was an inch or two lower than the concrete. Petitioner remembered telling someone she fell off the sidewalk, but did not remember if it was Ms. Harris. Petitioner acknowledged she had stepped in this area prior to the date of accident, but did not fall. She was aware there was an edge to the concrete in the area.

Petitioner acknowledged that the front of the building was not an area that was behind a fence. She confirmed that visitors can come to the building. She reviewed Petitioner's Exhibit 5(h), the aerial view of the facility, and testified that employees park in the parking lot at the bottom of the photo. She acknowledged this was also where visitors for the forensic building park, and acknowledged that visitors would take the same sidewalk she took to get into and out of the forensics building.

Petitioner reviewed Respondent's Exhibits 2(a), (b), and (c). She testified Exhibit 2(a) showed the front of the building, 2(b) showed a closer view of the sidewalk, and 2(c) showed a close-up of the area where Petitioner fell. She agreed that 2(c) showed more grass in the area than the photo previously viewed (Petitoner's Exhibit 5(e)).

Petitioner testified that her last visit with her treating physician was mid-February 2016, when he advised to continue with therapy and return to work full duty. She has not returned to see him since that time.

On re-direct examination, Petitioner testified that the curved sidewalk in front of the building was the only way she was authorized to leave the building. The only other means of exit is through a special area for law enforcement to pick up or drop off patients. Visitors are permitted in the building. The must provide an I.D., such as a driver's license, then they are given a wristband to wear during their visit. They go into a lobby outside of the control room, which is the same control room that she passed through as she left the building.

Both parties submitted various reports completed by Respondent, Petitioner, and witnesses following the accident. The Employer's First Report of Injury stated Petitioner was walking out of the building fell for an unknown reason and "thinks she felt like she stepped into a depression, lost footing and fell onto the concrete". It was noted she had broken her left shoulder and upper arm. RX1. Petitioner completed an Employee's Notice of Injury on September 17, 2015, and stated she left work and walked down the sidewalk to the center sidewalk. She saw two patients and after walking by them one patient asked if she had made any progress "on those trust fund papers". She looked back at him and answered, then looked forward. The next thing she remembered was "thinking I had stepped off the edge of the sidewalk stumbling, losing my balance and falling forward onto the sidewalk right in front of the street". RX1, PX2(a)

A Witness Report was completed by Margaret Harris on September 14, 2015. She stated she was on a smoking break and heard a crash by the sidewalk to the parking lot. She ran over and found Petitioner on the concrete sidewalk, holding her left arm. She wrote, "She said her foot slipped off concrete walk into the grass area, which was an inch or two lower than concrete and fell on sidewalk." RX1, PX2(c).

A Witness Report was completed by Johndolynn Meyer on September 14, 2015. She stated she was coming in from a trip and Petitioner was leaving, and they were on opposite sides of the circle. She wrote, "She appeared to trip on sidewalk, stumbled and fell, hands and elbow first, down on the concrete. She had been distracted by patient who was walking down while talking to her." PX2(b).

A Medical Emergency Flow Sheet was completed on September 14, 2015. It stated, "Employee reports foot stepped off the side of the concrete walkway, causing her to fall." RX1, PX2(d). A Supervisor's Report of Injury was completed by Ronald Floyd on September 17, 2015. He wrote, "On 9/14/15 at 16:30 while standing in front of the AFC building, talking w/2 patients, Ms. McGlasson tripped and fell, sustaining an injury to her left shoulder and left arm." RX1, PX2(e).

Following the accident, Petitioner presented to Washington University Physicians on September 18, 2015, and was examined by Dr. Aaron Chamberlain. She reported she had fallen on her left side while leaving work on September 14 and had been evaluated at the emergency room at Alton Memorial Hospital. Dr. Chamberlain reviewed x-rays and the CT scan, which revealed a fracture of the proximal humerus with significant comminution and extension into the diaphysis. She also had an anteroinferior dislocation of the humeral head into a fracture of the anteroinferior glenoid. PX3.

On September 21, 2015, Petitioner underwent surgery consisting of (1) open reduction and internal fixation of the left proximal humerus fracture, including the surgical neck, greater tuberosity, and proximal shaft; (2) open reduction of left shoulder dislocation; and (3) nonoperative treatment of the left glenoid fracture without manipulation. Surgery was performed by Dr. William Ricci of Washington University Physicians. PX3.

Petitioner followed up with Dr. Ricci postoperatively on October 13, October 27, November 10, and December 8, 2015. Her final visit with Dr. Ricci was February 16, 2016. She reported at that time that she was overall doing reasonably well. She was making some progress with therapy but was still having a little bit of stiffness and pain. On examination, range of motion actively showed forward flexion and abduction to about 90. Shoulder x-rays showed: (1) healed, internally fixated proximal left humerus fracture; (2) unchanged anteroinferior glenoid fracture with depression and articular incongruity; and (3) mild acromioclavicular joint osteoarthritis. Dr. Ricci recommended another four to six weeks of therapy with a focus on strengthening and range of motion. Petitioner was to continue light duty for another six weeks and then advance to full duty. PX3.

Petitioner underwent physical therapy at Apex Physical Therapy from November 13, 2015, through March 28, 2016. The Discharge Report of March 28, 2016, noted she had made objective improvements to progress toward her goals but still had functional range of motion deficits. Her strength had improved throughout the range and she found it easier to complete daily activities such as washing her hair and getting dressed. She still had some limitations with closing her car door, fixing her hair and holding the phone, and her arm tired easily. It was noted she had made as much progress as possible in skilled therapy and that she would continue her home exercise program. PX4.

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

To obtain compensation under the Illinois Worker's Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989). Both elements must be present in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill.2d 478, 483 (1989).

"In the course of employment" refers to the time, place and circumstances surrounding the injury. *Lee v. Industrial Comm'n*, 167 Ill.2d 77, 81 (1995). An injury is in the course of employment when it occurs within the period of employment at a place where the employee can reasonably be expected to be in the performance of his duties and while he is performing those duties or something incidental thereto. *Panagos v. Industrial Comm'n*, 171 Ill.App.3d 12, 15 (1st Dist. 1988).

The Arbitrator finds that Petitioner's accident occurred in the course of her employment. She was on the sidewalk in front of her building, where she might reasonably be expected to be at the end of her shift.

The "arising out of" component is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. A risk is incidental to the employment if it belongs to, or is connected with, what an employee has to do in performing his duties. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 203-204 (2003); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 58 (1989).

There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment, (2) personal risks, and (3) neutral risks that have no particular employment or personal characteristics. Employment risks are inherent in one's employment and include the obvious kinds of industrial injuries and occupational diseases that are universally compensated. Personal risks include exposure to elements that cause nonoccupational diseases, personal defects, or weaknesses. Whether an injury caused by a neutral risk arises out of employment is dependent upon whether claimant was exposed to a risk to a greater degree than the general public. *Illinois Institute of Technology Research Institute*, 314 Ill.App.3d 149, 162-163 (1st Dist. 2000).

In the case at bar, there is no evidence that the risk of injury was distinctly associated with Petitoner's employment. In addition, there is no evidence that Petitioner's fall was the result of a personal risk. As such, this case involves the third category, that being a neutral risk. Whether an injury caused by a neutral risk arises out of employment is dependent upon whether claimant was exposed to a risk to a greater degree than the general public. *Illinois Institute of Technology Research Institute*, 314 Ill.App.3d at 163. Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. *Metropolitan Water Reclamation District of Greater Chicago v. Ill. Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1014 (1st Dist. 2011).

Petitioner put forth three theories as to how she was exposed to an increased risk and thus why her accident arose out of employment: (1) the area in which she fell was not open to the general public; (2) a defect in the sidewalk created a special hazard; and (3) she was talking to and distracted by a patient and thus engaged in her occupation at the time of the fall.

With regard to the first theory, Petitioner testified that the facility is accessible to visitors, who must follow the rules of the facility. Visitors park in the same parking lot as employees, take the same sidewalk that she took, and enter and exit the building through the same doors as employees. While it cannot be said that this facility was "public" to the extent that other workplaces may be, it also cannot be said that it was not open to the public. For those members of the public that do visit this facility, their journey into and out of the building is no different than Petitioner's. The Arbitrator is not persuaded by this argument.

With regard to Petitoner's second theory, both parties submitted pictures of the sidewalk, the front of the building, and the general area where Petitioner fell. Petitioner testified that the ground was about two inches lower than the sidewalk where she fell, that the sidewalk curved, and that the sidewalk went from a wide area to a narrow area "and if somebody's coming you kind of just sometimes will step off". The Arbitrator finds none of these assertions rise to the level of a defect in the sidewalk so as to have created a special hazard. Although the pictures seem to suggest that the ground was somewhat lower than the sidewalk, such is the case with most sidewalks. A sidewalk typically has ground on either side of it, which settles over time, or has a curb on one side of it. The general public faces this on a daily basis. The same is true of the shape of the sidewalk. The Arbitrator has viewed the pictures and finds that the width of the sidewalk area at the narrowest points still appears to be the standard width for a sidewalk. Again, curves in sidewalks and walkways, and transitions to and from wider areas of walkway are very common and are faced by the general public on a daily basis.

The Arbitrator finds the condition of the sidewalk in this case to be analogous to *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52 (1989). In that case, the Illinois Supreme Court found that an employee's fall on a defect-free curb did not arise out of his employment because the injury resulted from a risk to which the general public was exposed. The Arbitrator has reviewed the case of *Brais v. Illinois Workers' Compensation Comm'n*, 2014 IL App (3d) 120820WC, 10 N.E. 3d 403 (3rd Dist. 2014) and finds it distinguishable from the case at bar. In *Brais*, the evidence showed that the sidewalk where claimant fell was defective, in that it had huge cracks and was broken up and crumbled, to the extent that the gravel under the concrete was visible. The Appellate Court found in that case that the condition of the sidewalk created a special hazard and was a contributing cause of claimant's injury, as her heel caught on the defective sidewalk and caused her to fall. The Court distinguished the case from *Caterpillar*, in which the Supreme Court found no evidence of a defect and found that the curb was like any other curb. *Id*, at 26-27. In that the Arbitrator has found that there was no defect in the sidewalk in the case at bar, the Arbitrator finds *Caterpillar* to be controlling.

With regard to Petitioner's third theory, that she was talking to and distracted by a patient and thus engaged in her occupation at the time of the fall, the Arbitrator finds this to be a compelling argument. Although Petitioner actually fell because of her own misstep, the Arbitrator finds the misstep was caused by her attention being focused on the patient with whom she was talking, rather than on where she was walking. Because the patient was behind her, she had to turn back around to talk with him and when she turned forward again, she lost her footing.

The Arbitrator finds that Petitioner's injury had an origin in a risk arising out of her employment and thus was connected to her employment. Petitioner met her burden of proof in establishing that an accident occurred which arose out of and in the course of her employment.

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

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

Respondent's dispute with regard to causation was as to accident only. Respondent agreed that the injury sustained did result from the fall at issue. In light of the Arbitrator's findings above with respect to issue (C), the Arbitrator finds that Petitioner's current condition of ill-being with regard to her left shoulder and arm is causally related to her work accident of September 14, 2015.

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

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

The Arbitrator notes there was no dispute between the parties that the treatment rendered, including surgery, was reasonable and necessary. The only dispute was whether it was causally related to a compensable work accident. In light of the Arbitrator's findings with respect to issues (C) and (F), the Arbitrator finds that medical services rendered to date were reasonable and necessary in Petitioner's care and treatment relative to her accident of September 14, 2015. The Arbitrator finds Respondent is liable for outstanding medical bills as set forth in Petitioner's Exhibit 6, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts previously paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent is liable for the following medical bills:

1. Washington University Physicians	$14,056.00
2. Apex Network Physical Therapy	$18,595.50
TOTAL	**$32,651.50**

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

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

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

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Social Worker at the time of the accident and that she was able to return to work in her prior capacity without restrictions as a result of said injury. Petitioner testified that the patients frequently showed aggression and she had to be able to block a hit and/or contain patients if they were attacking someone else. This happened on a weekly basis. She did not believe she had the strength or mobility to do so. The Arbitrator places significant weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 58 years old at the time of the accident. She returned to her prior capacity without restrictions. She testified she was retiring the week of her hearing, in part due to her decreased strength and mobility and her lack of confidence in her ability to protect herself and others from aggressive patients. Over time her condition could improve, stay the same, or get worse. The Arbitrator gives some weight to this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner returned to her prior position full duty and was scheduled to retire the week of the hearing. There is no evidence to show that Petitoner's future earning capacity was impacted by the injury. The Arbitrator gives no weight to this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes Petitioner sustained a fracture of the proximal humerus with significant comminution and extension into the diaphysis, as well as an anteroinferior dislocation of the humeral head into a fracture of the anteroinferior glenoid. She underwent surgery consisting of (1) open reduction and internal fixation of the left proximal humerus fracture, including the surgical neck, greater tuberosity, and proximal shaft; (2) open reduction of left shoulder dislocation; and (3) nonoperative treatment of the left glenoid fracture without manipulation. Her complaints and limitations are well-documented in the medical records. Petitioner testified she continues to have stiffness, pain, lack of mobility, and lack of strength. She cannot raise her arm much above her shoulder. She has difficulty with daily activities such as taking clothes out of the dryer, getting things on and off a shelf, putting on her bra, pulling her pants up, hanging clothes, using an ATM, reaching for food in a drive-thru, lifting heavy bags, and the like. She testified she does many of these activities one-handed now, due to the problems with her left arm and shoulder. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained 25% loss of use of the person as a whole (125 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $1,708.62. The Arbitrator finds that her permanent partial disability rate is $755.22, which is the statutory maximum rate applicable to her date of accident.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Peabody,

Petitioner,

18IWCC0374

vs.

NO: 13 WC 11532

Environmental Technical Institute,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary disability, medical expenses, and the nature and extent of the injury and being advised of the facts and law, reverses the Decision of the Arbitrator, which is attached hereto. The Commission further remands this case to the Arbitrator for further proceedings for a determination of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Petitioner, a 39-year-old welding instructor, alleged injuries to his right shoulder on September 12, 2012. On that date, Petitioner slipped and fell at the Elgin scrap yard while gathering materials for his courses at Environmental Technical Institute, he sustained an elbow laceration and he felt pain in his right shoulder for which he sought treatment at the emergency room the following day. The Arbitrator found that Petitioner sustained, at most, a sprain or strain of the right shoulder that resolved no later than by December 10, 2012. After considering all the evidence, and for the reasons set forth below, we reverse the Decision of the Arbitrator and award medical expenses for reasonable and necessary right shoulder treatment and prospective medical treatment recommended by Dr. Alpert.

Petitioner had a prior episode of right shoulder pain in 2009 as documented in the medical records of his primary care physician, Dr. Guevara. However, there is no evidence of treatment for the right shoulder for over two years until the September 12, 2012 accident. Petitioner went to the Alexian Brothers Medical Center emergency room the day after the accident and complained of pain in his right shoulder, wrist, and neck after tripping and landing on his right arm at the scrap yard one day earlier. Petitioner further complained of difficulty lifting his right arm. An x-ray was negative for fracture or dislocation, and he was diagnosed with a shoulder sprain.

Petitioner followed up with Dr. Guevara on September 18, 2012. Petitioner gave Dr. Guevara a history of the accident on September 12, 2012 and his emergency room treatment. Petitioner reported that he had continued working despite severe pain, tenderness, and difficulty raising his right arm. Dr. Guevara recommended an MRI for further evaluation. The October 5, 2012 MRI report indicated a partial thickness tear of the supraspinatus tendon, acromioclavicular joint arthropathy, and biceps tenosynovitis. Dr. Guevara reviewed the MRI report and noted tendinosis of the supraspinatus, acromioclavicular arthropathy, and right biceps tenosynovitis, but he did not mention the partial thickness tear of the supraspinatus tendon. Dr. Guevara recommended a course of physical therapy. Petitioner participated in physical therapy for six weeks and continued working regular duty. Dr. Guevara noted that Petitioner was also treating for chronic back problems. Petitioner injured his right knee in early January of 2013 and underwent knee surgery in February of 2013 by Dr. Qeli at Northern Illinois Orthopaedic & Rehabilitation. Petitioner did not resume treatment for his right shoulder until April of 2013.

On April 5, 2013, Petitioner first gave Dr. Qeli a history of injuring his right shoulder on September 12, 2012 when he tripped and fell at the scrap yard. Dr. Qeli reviewed the MRI images, but noted that he did not have the MRI report. He interpreted the MRI images as revealing tendonitis of the right shoulder but "no large tear." Dr. Qeli recommended physical therapy for the right shoulder, and Petitioner began following up with Dr. Qeli with respect to his right shoulder as well as his post-operative right knee. As of May 15, 2013, Petitioner was still off work for his right knee. On that date, Dr. Qeli allowed Petitioner to return to work light duty with no lifting over ten pounds. However, Petitioner did not work again until February of 2014 when he started working as a welding instructor for a new employer, First Institute Training & Management.

Petitioner was examined by Dr. Walsh, a board certified orthopedic surgeon at DuPage Medical Group, at the request of Respondent, on December 19, 2013 and July 9, 2015. Dr. Walsh opined that Petitioner's right shoulder condition was related to the normal aging process and not any injuries sustained on September 12, 2012. Dr. Walsh noted Petitioner's history of right shoulder pain in 2009 and x-ray imaging in 2010. Dr. Walsh's opinion was that the MRI results were entirely explained by Petitioner's age. Respondent denied benefits for any right shoulder treatment after December of 2012.

Petitioner continued to follow up with Qeli throughout 2013 for ongoing right shoulder

and right knee pain. Petitioner did not have the physical therapy repeatedly recommended by Dr. Qeli as it was not authorized by Respondent. Dr. Qeli performed a therapeutic right shoulder injection on August 14, 2013 and an ultrasound on October 9, 2013. Dr. Qeli discussed the diagnostic "limitations of the ultrasound exam," but he noted that he did not see any "large tear." Dr. Qeli continued to recommend physical therapy and to see Petitioner periodically through 2014 and 2015. Dr. Qeli stated that he would not consider surgical treatment without first attempting a complete course of physical therapy.

On August 22, 2016, Petitioner sought treatment with a new provider, Dr. Alpert at Midwest Bone & Joint Institute. He reported a history of the right shoulder injury on September 12, 2012 with subsequent treatment by Dr. Qeli. Petitioner reported that he no longer worked for the employer where the accident happened. He reported that he still works as a welding instructor, but he is not able to lift or do overhead welding. Dr. Alpert recommended a new MRI for further evaluation of the right shoulder. Dr. Alpert reviewed the September 2, 2016 MRI and interpreted it as showing evidence of a significant full-thickness rotator cuff tear in the presence of an OS acromiale and degenerative changes of the acromioclavicular joint. Dr. Alpert injected Petitioner's right shoulder and recommended physical therapy. Petitioner began physical therapy at NovaCare Rehabilitation on October 19, 2016 and continued therapy until November 18, 2016.

On November 27, 2016, Dr. Walsh reviewed updated records and the MRI from September 6, 2016 and issued a letter with respect to his opinions. Dr. Walsh noted that the radiologist interpreting the MRI did not identify a rotator cuff tendon or glenoid labrum tear. Dr. Walsh stated that there was no change in his opinion due to the new records he reviewed. He stated that he believed Petitioner's new MRI results were still essentially normal for his age.

Petitioner's course at First Institute Training & Management ended in November of 2016 and he has not worked since that time. He testified that there were no jobs available at First Institute Training & Management within his restrictions. Petitioner began another course of physical therapy, this time at the Athletic & Therapeutic Institute, on December 8, 2016. Petitioner last saw Dr. Alpert on December 21, 2016. Dr. Alpert recommended continued physical therapy and restrictions of no lifting over ten pounds with the right arm.

The Arbitrator found that Petitioner failed to provide sufficient evidence to prove that his current condition of ill-being in the right shoulder is causally related to the accident. We view the evidence differently, and we reverse to find that Petitioner's right shoulder condition is causally related to the accident based on the chain of events. A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient to prove a causal nexus between the accident and the employee's injury. *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

Petitioner's description of the accident is undisputed. He testified that he was not having any right shoulder pain or problems prior to the date of accident. On September 12, 2012 he fell

from the top of a pile of scrap metal while searching for iron materials that he could use in his classroom. Petitioner testified that he attempted to use his right arm to break that fall, and that he experienced severe right shoulder pain immediately after as he attempted to lift a piece of metal into his truck. Petitioner provided a consistent history of the accident to all medical providers and Petitioner consistently presented to his medical providers with complaints of right shoulder pain, tenderness, and difficulty raising his right arm above his shoulder. The October 5, 2012 MRI identified an articular partial thickness tear in the right supraspinatus tendon near its insertion. Although they had different interpretations of the diagnostic imaging, Petitioner's treating physicians, Dr. Guevara, Dr. Qeli, and Dr. Alpert each found a causal connection between Petitioner's accident and his right shoulder condition. Furthermore, the record is void of any evidence establishing an additional cause for this injury. The gap in treatment between December 2012 and April of 2013 can be reasonably explained by Petitioner's knee treatment, and there is nothing in the record showing that Petitioner's right shoulder condition ever improved or resolved after September 12, 2012. As of the date of hearing, Petitioner was still treating with Dr. Alpert for his right shoulder and attending physical therapy. We find that Petitioner needs further medical treatment for the right shoulder injuries sustained on September 12, 2012 and we award prospective treatment as recommended by Dr. Alpert.

Although we find causal connection for Petitioner's right shoulder condition and medical treatment, we do not award temporary total disability benefits. We find that Petitioner failed to prove that he did not work and was unable to work because of his right shoulder condition for the periods of time from May 15, 2013 to February 5, 2014 and from November 9, 2016 through the date of arbitration. As of May 15, 2013, Petitioner was still off work for his knee injury and surgery. Dr. Qeli's notes on that date indicate that Petitioner could work light duty with no lifting over ten pounds, but there is no evidence that Petitioner ever attempted to return to work for Respondent or find other employment until the fall of 2013. In November of 2013, Petitioner interviewed for a job as an instructor at First Institute Training & Management and started working there in February of 2014. Petitioner testified that he could fully perform his job as an instructor at First Institute Training & Management as it did not require any lifting. Petitioner testified that in November of 2016 the course he was teaching at First Institute Training & Management ended. He claimed entitlement to temporary total disability benefits from November 9, 2016 through the date of hearing as he was still under ten-pound restrictions by Dr. Alpert. Petitioner agreed that he would have started teaching another course at First Institute Training & Management if one was available. There is no evidence that Petitioner looked for any other work within his restrictions. We do not find that Petitioner proved after November 9, 2016 he did not work and was unable to work because of his right shoulder injury.

Finally, we affirm the Arbitrator's denial of penalties and fees for the reasons set forth by the Arbitrator and we remand this case to the Arbitrator on the remaining issue of permanent disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay all reasonable and necessary medical expenses for right shoulder treatment related to the accident of

18IWCC0374

September 12, 2012 as reflected in Petitioner's Exhibit 13 and pursuant to §8(a) and 8.2 of the Act and the applicable fee schedule. It is further ordered by the Commission that Respondent shall authorize and pay for prospective medical treatment for Petitioner's right shoulder; Dr. Alpert's current recommendation is for continued physical therapy.

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 $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 12 2018
DLS/plv
o-5/24/18
46

Deborah L. Simpson

David L. Gore

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0374

PEABODY, MICHAEL
Employee/Petitioner

Case# **13WC011532**

13WC011531

ENVIRONMENTAL TECHNICAL INSTITUTE
Employer/Respondent

On 5/12/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5669 ALEKSY BELCHER
ALEX M TILLETT-SAKS
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

0507 RUSIN & MACIOROWSKI LTD
JEFFREY T RUSIN
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

18IWCC0374

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

MICHAEL PEABODY
Employee/Petitioner

v.

ENVIRONMENTAL TECHNICAL INSTITUTE
Employer/Respondent

Case # 13 WC 11532

Consolidated cases: 13 WC 11531

An *Application for Adjustment 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 (WHEATON II)**, on **12/29/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **9/12/12**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$59,999,68**; the average weekly wage was **$1,153.84**.

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 $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Petitioner's condition of ill-being is not causally related to his work related accident on 9/12/12.

The Arbitrator finds that, at most, Petitioner sustained a sprain/strain of the right shoulder that resolved no later than December 10, 2012.

The Arbitrator finds that the Respondent is not liable for any alleged outstanding medical bills after December 10, 2012.

Petitioner's claims for penalties/fees as well as TTD 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.

Jessica A. Kozatt

Signature of Arbitrator

5/11/17
Date

MAY 12 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL PEABODY, Petitioner,	)	
vs.	)	**13 WC 11532** *consolidated with:* *13 WC 11531*
ENVIRONMENTAL TECHNICAL, INSTITUTE Respondent.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

13 WC 11531

The parties agreed that the nature and extent of Petitioner's 1/27/12 accident would be determined at a later time. Therefore, no decision will be issued by the Arbitrator at this time with respect to 13 WC 11531.

13 WC 11532

On 9/12/12, Petitioner was working for Respondent as a welding instructor and welding program manager. (Tx 9). His job duties included teaching individuals how to weld gas metal, arc welding, shielded metal arc welding, gas tungsten arc welding, oxy fuel cutting, and plasma arc cutting. (Tx 10). He testified that he was required drive from Itasca to a scrapyard in Elgin on a regular basis to retrieve iron materials for instructional use in the classroom. (Tx 10-12).

On 9/12/12, Petitioner drove to a scrapyard in Elgin where he climbed on top of a pile of guardrail to recover material for his class. After selecting some material, he tossed it down to the ground in order to retrieve later. (Id.). Later, as he was climbing down off the pile of metal, his boot became caught on a piece of guardrail causing him to fall to the ground. (Id.). As he was falling, Petitioner extended his right arm to break his fall. (Tx 14-15).

He eventually stood up and attempted to gather the various guardrail materials off the ground but, as he did so, he noticed severe pain in his right shoulder. (Tx 15).

He returned to work and notified Respondent's vice president of operations of his accident, who in turn, advised Petitioner to seek medical attention. (Tx 16).

Records from Alexian Brother Medical Center indicate that Petitioner presented on 9/13/12, with complaints of pain in his right shoulder, right wrist and neck after tripping and landing on his right arm in a scrap yard. (Px 3) Petitioner reported pain when lifting his right arm. Abrasions on his forearm were noted. Petitioner reported taking Vicodin for back pain. (Id.). On exam, pain along the posterior and superior aspects of Petitioner's right shoulder were noted along with pain on forced abduction. (Id.). X-rays of the right shoulder showed no fracture, dislocation or bony trabecular abnormality. A tiny bone island was visible at the humeral head.

(Id.). Petitioner was diagnosed with a right shoulder sprain, provided a sling, ice pack, and prescribed Naprosyn for pain and Flexeril for muscle spasms. (Id.).

On 9/18/12, Petitioner reported persistent right shoulder pain to family physician, Jose R. Guevara, M.D., who noted an accident history consistent with Petitioner's testimony at the hearing. (Px 4). On exam, the doctor noted tenderness in the right anterior shoulder and discomfort with rotation and arm raising. (Id.). Dr. Guevara diagnosed a rotator cuff and AC joint ligament sprain and recommended an MRI of the right shoulder. (Id.).

On 10/5/12, a right shoulder MRI noted:

- Supraspinatus tendinosis with an articular partial thickness tear near its insertion;
- Type II acromium process with arthropathy at the acromioclavicular joint likely resulting in impingement;
- Small collection in the subacromiodeltoid bursa;
- Bicep tendon tenosynovitis (Id.).

On 10/9/12, Petitioner followed-up with Dr. Guevara who noted complaints of persistent right shoulder pain. On exam, tenderness to the right anterior bicep and pain on forced arm raise was noted. The doctor reviewed the recent MRI and instructed Petitioner to begin occupational therapy. (Id.).

Petitioner presented for initial evaluation on 10/23/12 at Accelerated Rehabilitation Centers where he reported working full duty but doing as little as possible with his right arm while at work. (Id.). On exam, Petitioner was noted to have reduced range with pain on abduction, flexion and rotation. (Id.). Hawkins-Kennedy test for impingement along with Speeds and apprehension testing were positive. Tenderness to the inferior acromion process and the glenohumeral head were noted. (Id.). It was recommended that Petitioner continue with physical therapy twice a week for the next 6 weeks. (Id.).

On 12/10/12, Petitioner followed up with Dr. Guevara who noted persistent right shoulder complaints. (Px 4). Petitioner testified that Respondent stopped authorizing medical treatment after that visit. (Tx 21).

Petitioner testified that he began to develop unrelated knee problems in early 2013 for which he saw Dr. Queli.

The records from Albi Queli, M.D. show that Petitioner presented on 1/16/13 and 1/30/13 with complaints related to his right knee. (Px 6). The doctor did not note any complaints of pain with respect to Petitioner's right upper extremity at either visit. (Id.). Dr. Queli eventually performed right knee surgery in late February of 2013. Following that surgery, Petitioner continued to treat with Dr. Queli regarding his right knee.

Petitioner's first complaint regarding his right shoulder to Dr. Queli occurred on 4/5/13. (Tx 23; Px 6). Dr. Qeli noted a history of a work related accident on 9/12/12. Petitioner reported that he still could not lift his right arm above his head. (Id.). Petitioner followed up with Dr. Qeli on 5/15/13, at which time, Dr. Qeli diagnosed right shoulder impingement and tendinosis. Light

duty restrictions were instituted. (Tx 24; Px 6). According to Petitioner, Respondent was not able to accommodate those restrictions. (Tx 25).

On 7/10/13, Dr. Qeli recommended Petitioner stay off work and obtain a right shoulder injection which was administered one month later. (Tx 26; Px 6). Petitioner testified he felt improvement after the injection. (Id.).

On 10/9/13, Dr. Qeli noted Petitioner could return to work with restrictions of no abduction with weights and no raising the right arm above shoulder level. (Tx 27; Px 6). Petitioner testified Respondent was not able to accommodate those restrictions. (Id.).

Petitioner interviewed for a new job at First Institute Training & Management in November 2013. (Tx 27). He began working for them on 2/6/14. (Id.).

Petitioner continued to follow up with Dr. Qeli through 4/13/15, with complaints of right shoulder pain and an inability to lift his right arm above his head. (Tx 27-28, Px 6). Dr. Qeli continually recommended physical therapy and an updated MRI for the right shoulder, however, said treatment recommendations were denied by Respondent's carrier. (Tx 28, Px 6).

Petitioner testified he was then referred to Dr. Joshua Alpert by Dr. Guevara due to the fact that Dr. Qeli left his medical practice. (Tx 29-30).

Petitioner consulted with Dr. Alpert at Midwest Bone & Jone Institute on August 22, 2016. (Tx 29, Px 10). Dr. Alpert noted a diagnosis of right shoulder pain and weakness from a work-related injury in 2012 consistent with a rotator cuff tear. (Tx 30; Px 10). Dr. Alpert recommended an updated MRI and light duty restrictions of no right arm lifting. (Id.).

On 9/2/16, Petitioner obtained the recommended MRI which noted:

- No non-arthographic MRI evidence of a rotator cuff tendon or glenoid labral tear.
- Persistent os acromiale with minimal degenerative changes about the synchondrosis as well as minimal degenerative changes at the subacromioclavicular joint. (Px 10).

Dr. Alpert reviewed the MRI with Petitioner on 9/12/16 noting no evidence of "obvious significant full thickness rotator cuff tear" and the presence of an os acromiale with some degenerative changes about the AC joint. (Id.). Dr. Alpert noted a diagnosis of right shoulder pain and weakness with a possible rotator cuff tear from a work-related injury in 2012. (Id.). Petitioner received an injection at that visit, and began physical therapy on 10/19/16 at NovaCare Rehabilitation. (Tx 31, Px 10, Px 11). Respondent authorized the previously mentioned treatment.

Petitioner followed up with Dr. Alpert on 11/9/16. (Tx 32, Px 10). Although Petitioner believed physical therapy was helping his right shoulder, he complained of persistent pain. (Id.). Dr. Alpert maintained the same work restrictions of no lifting with the right arm. (Id.). Petitioner's new employer, First Institute Training & Management, was no longer able to accommodate Petitioner's light duty restrictions as the class he was teaching had ended. (Tx 32-33). Petitioner has been off work since November 9, 2016. (Tx 33). On 12/21/16, Dr. Alpert adjusted Petitioner's light duty restrictions to no lifting more than 10 lbs. with the right arm and continued to recommend physical therapy. (Tx 34, Px 10).

Petitioner testified he did not receive any benefits from his employer for his time off work from 5/15/13 through 2/6/14. (Tx 35). Petitioner further testified his employer has not paid any benefits for his time off work from 11/9/16 through the date of the hearing.

On cross-examination, Petitioner confirmed the written job description furnished by Respondent did not include going to a scrapyard to obtain materials for his class. (Tx 40, Rx 1).

Petitioner testified he had previous workers' compensation claims in 1995, 1996 and 1997 while working for Applied Web Systems, and a lumbar spine workers' compensation injury on September 28, 2001 while working for Illinois Blower. (Tx 42).

Petitioner testified he was taking one Vicodin per day at the time of the accident due to chronic low back pain. (Tx 47). Petitioner confirmed that prior to this accident, he presented to Dr. Guevara on 12/28/09 with a history of "right shoulder pain, fell a couple years ago, is becoming bothersome." (Tx 49; Rx 2). Petitioner testified he did not recall treatment for his right shoulder with Dr. Guevara in 2009 nor did he remember receiving x-rays of the right shoulder on 2/9/10. (Tx 49.).

Petitioner testified that despite his right shoulder injury, he worked from September 2012 through December 10, 2012. (Tx 51.). He did not recall if Dr. Guevara provided full duty restrictions at that time. (Id.). He treated with Dr. Qeli from January 2013 through March of 2013 for his knee. (Tx 52). Petitioner testified he did not discuss his right shoulder pain with Dr. Qeli in January and February of 2013 because such discussion would have required him to make a separate appointment. (Tx 52-53). Petitioner confirmed the first time he discussed his right shoulder injury with Dr. Qeli was in April 2013. (Tx 53). He confirmed he was off work at that time due to his knee pain. (Id.)

Petitioner confirmed he treated with Dr. Qeli for his right shoulder on a monthly basis through 7/23/14 and that he did not treat with Dr. Qeli for his right shoulder from July 2014 until March 2015. (Tx 57) His last date of treatment with Dr. Qeli was April 13, 2015. (Tx 58). Petitioner did not receive right shoulder treatment from April 2015 until he saw Dr. Alpert in August 2016. (Id.). Petitioner confirmed he was actively treating during that time frame for his low back with Dr. Giese. (Tx 59). Petitioner testified he was taking Norco for low back pain during that time frame. (Tx 59-60). Petitioner testified he was working full-time during that time, but not full duty. (Tx 60). Petitioner testified his students could lift what he needed to lift, and the material weighed less than 10 lbs. (Id.) Petitioner testified he did all his welding with his left hand during that time frame. (Id.).

On re-direct examination, Petitioner confirmed Respondent's description of Petitioner's job includes the duty to "oversee and maintain the welding lab by insuring its clean, equipped and stocked according for desired training programs." (Tx 64, Rx 1, Px 14). Petitioner testified the class room needed to be stocked with stainless steel and iron. (Tx 65-66). Petitioner testified they would get iron for the welding lab by either going to the scrapyard or receiving certification material from a supply company. (Id.).

Petitioner testified he discussed his work restrictions with Rick Miller and Kirk Biler at First Training Institute and advised he could not lift more than 10 lbs. (Tx 67). They advised that those restrictions could be accommodated until the course ended on 9/9/16. (Tx 67-68). Petitioner further testified in 2009 through 2010 he was treating with Dr. Guevara for his low back. (Tx 68-70). During that time frame, Petitioner reported right shoulder pain one time.

(Id.). Petitioner testified Dr. Qeli mentioned a possibility of surgery at one time, but Petitioner needed further physical therapy to determine if surgery was needed. (Tx 71).

On re-cross examination, Petitioner testified when a course ended at First Training Institute he would start a new course if there was one available. (Tx 72). If no new course was available the only other option for work at First Training Institute was maintenance on the trailer. Id. Petitioner testified he was unable to perform maintenance on the trailer due to his physical restrictions. (Id.).

On further re-direct examination, Petitioner confirmed if he did not have restrictions in place on his right shoulder he would be able to perform maintenance on the trailer. (Tx 73). Petitioner confirmed he would have been paid at the same rate as teaching for performing maintenance on the trailer. (Id.).

Dr. Walsh performed two section 12 examinations on 12/19/13 and 7/9/15. The doctor noted a diagnosis of tendinosis, tenosynovitis and AC joint arthropathy which, in his opinion, was not causally related to the work accident. He noted that Petitioner could return to work without restrictions and did not need any further treatment at the time of his examinations.

CONCLUSIONS OF LAW

Accident

The Arbitrator finds that Petitioner's accident of 9/12/12, arose out of and in the course of his employment, with the Respondent as Petitioner was performing his required work duties when the injury occurred. The Arbitrator based this finding on Respondent's job description which included the duty to "oversee and maintain the welding lab by insuring it's clean, equipped and stocked according for desired training programs." Petitioner testified this included going to a scrapyard in Elgin to obtain materials for the class, which is where the injury occurred.

The Arbitrator notes Respondent did not present any factual witnesses disputing the work accident.

Notice

The Arbitrator finds Petitioner provided timely notice of the accident to Respondent within 45 days of the work accident. Petitioner's unrebutted testimony is that: 1. His manager, Ron Bellinger, witnessed the accident and 2. That he notified Maryann Caniglia, vice president of operations for Respondent, the same day of the accident when he returned to Respondent's location in Itasca.

Causal Connection

As stated above, the Arbitrator finds Petitioner sustained an accident that arose out of and in the course of his employment although the Arbitrator questions the severity of the injury. The Arbitrator finds, at most, the Petitioner sustained a laceration to the elbow and a sprain/strain to the right shoulder as a result of the slip and fall on 9/12/12.

Petitioner's initial medical treatment at Alexian Brothers, the day after the incident, revealed a diagnosis of a strain/sprain. Petitioner underwent right shoulder x-rays which were normal. (Px. 1). Petitioner then began treating with his primary care physician, Dr. Guevara, who is not

an orthopedic physician. (Rx. 2; Px. 4). Petitioner was diagnosed with a rotator cuff strain and an AC joint strain. Petitioner eventually underwent an MRI on 10/5/12 that noted tendonitis, biceps tenosynovitis, and type II acromion. The MRI did not reveal any significant traumatic findings.

Petitioner did undergo physical therapy for the right shoulder, approved by the Respondent, for approximately two months from October of 2012 to December of 2012. Petitioner was working full duty without restrictions during this time. (Px. 5). Petitioner last treated with Dr. Guevara on 12/10/12 for his alleged right shoulder condition.

The Arbitrator finds it significant that after 12/10/12, Petitioner was working full duty without restrictions and did not seek any medical treatment or allege any right shoulder complaints for a four month period of time, until April of 2013. (Px. 4; Px. 6).

In January of 2013, while Petitioner was still working full duty and not undergoing any medical treatment for his right shoulder, Petitioner sustained an injury to his right knee which caused him to seek treatment with orthopedic physician, Dr. Qeli in January of 2013. (Px. 6). Petitioner treated on numerous occasions with Dr. Qeli from January through April of 2013, and even underwent an operation on the knee in February of 2013. However, during his multiple visits with Dr. Qeli, Petitioner never mentioned any shoulder problems or symptoms until April of 2013 when he reported right shoulder problems which he alleged were a result of an injury in September of 2012. (Px. 6).

The Arbitrator notes that upon review of the MRI films, Dr. Qeli diagnosed that Petitioner had tendinitis in the right shoulder, nothing more.

The Arbitrator questions the credibility of the Petitioner and the severity of Petitioner's alleged ongoing shoulder problems considering that there is no mention of such complaints in his many visits with Dr. Qeli from January through April of 2013. The Arbitrator notes that Petitioner initially testified that he did inform Dr. Qeli of his shoulder condition in January of 2013, but later recanted that statement after being shown the medical records. Even though Petitioner had an unrelated right knee problem, if Petitioner's shoulder pain was as he alleged and testified to, the Arbitrator finds that any reasonable individual would acknowledge said pain and limitations at some point during his regular follow up visits from January through April of 2013.

The Arbitrator notes that in May of 2013, Dr. Qeli completed an "Accidental Injury Claim Form" relating specifically to Petitioner's right knee, nothing related to the right shoulder. (Px. 6).

The Arbitrator also notes that on 5/7/13, Petitioner returned for a follow up visit with Dr. Guevara (Px. 2). At that time, Petitioner complained of chronic low back pain and issues with his diabetes. Petitioner denied any right upper extremity pain or symptoms. Petitioner did not receive any treatment or diagnoses for his alleged ongoing right shoulder/upper extremity condition. One week later, on 5/15/13, Petitioner began complaining of right shoulder pain again.

Physical therapy records from McHenry County Physical Therapy for Petitioner's right knee, document various physical activities that would appear to be beyond the restrictions provided for Petitioner's alleged shoulder condition. (Px. 9). In fact, such records from April 2013 through June 2013 document Petitioner installing appliances and performing yard work.

The Arbitrator notes that from 7/23/14 until 3/31/15, a period of almost 8 months, Petitioner *did not* receive any medical treatment for his alleged ongoing right shoulder problems and did not document any complaints of pain to the right shoulder.

After receiving no treatment for 8 months, Petitioner returned for a follow up with Dr. Qeli in March of 2015, at which time, he reported continued problems in the right shoulder. (Px. 6).

The Arbitrator notes that Petitioner's next medical visit for any examination or treatment for his right shoulder was not until 8/22/16. (Px. 10). This is a period of one year and four months.

The medical records from Caring Clinic from 11/2/15, 3/1/16, 4/26/16, and 8/1/16 establish that Petitioner reported multiple complaints for a variety of conditions without mention of ongoing right shoulder pain. (Rx. 9).

On 11/2/15, Petitioner presented to Dr. Giese for an adult wellness check for his type II diabetes, hyperlipidemia and hypertension as well as chronic low back pain. The record indicates that Petitioner was alleged scheduled for lumbar spine surgery, which he was hesitant about. There is no mention of a right shoulder injury or problem. Petitioner reported taking Norco 3-4 times a day. Petitioner provided a history of knee surgery which occurred back in February of 2013. (Rx. 9). The Arbitrator notes that Petitioner's follow up visits with Dr. Giese in March and April of 2016 relate to Petitioner's diabetes, high cholesterol and hypertension. (Rx. 9). The records also document Petitioner's ongoing low back pain. The records show that Petitioner was requesting an MRI for his low back pain. (Petitioner denied seeking an MRI on the lumbar spine at trial). Petitioner also requested a referral for a pain management specialist due to his low back pain.

Again, it is significant that Petitioner never made any mention of his alleged ongoing right shoulder pain.

Petitioner last treated at the Caring Clinic in August of 2016, the same month that he began treatment with Dr. Alpert. On 8/1/16, Petitioner was having issues with his diabetes and was also seeking a referral for a pain doctor for his low back pain. Petitioner was diagnosed with type II diabetes mellitus, tobacco dependence, obesity, patellar tracking disorder of the right knee as well as a chronic lumbar strain. Petitioner was given updated medications for his diabetes and referred to an endocrinologist. Petitioner was prescribed some additional medications for his lumbar spine pain and was given a referral to a pain clinic. It was noted that Petitioner claimed that he exercised and/or was regularly active at work. It was indicated that Petitioner worked as a laborer of some sort. Petitioner was told to return on an as needed basis. (Rx. 9). Again, there is no mention of any right shoulder pain. The Arbitrator notes Petitioner's report of exercising regularly and being active at work and has difficulty reconciling such as report with his alleged right shoulder limitations.

Despite Petitioner's testimony that Dr. Guevara referred him to Dr. Alpert, the medical records document that he sought treatment with Dr. Alpert at the recommendation of his mother and attorney. (Px. 10). The Arbitrator notes that the initial history provided to Dr. Alpert differs from the testimony at trial and is inconsistent with the medical records. (Px. 10).

The Arbitrator also analyzed Petitioner's updated MRI report of the right shoulder in 2016, which revealed only minimal degenerative findings in the shoulder with no tearing of either the rotator cuff or the labrum (Px. 10).

Petitioner underwent PT at NovaCare Rehab from 10/19/16 through 11/28/16 with no significant improvement. (Px. 11). The Arbitrator also notes inconsistent histories provided to his therapists at NovaCare Rehabilitation, specifically relating to his functional requirements and job duties/description. (Px. 11).

The Arbitrator finds that Petitioner has failed to provide sufficient evidence to prove that his current condition of ill-being is causally related to the work related incident on 9/12/12. The Arbitrator notes that despite his alleged complaints of ongoing pain and symptoms, Petitioner had multiple gaps in treatment of four months, (12/10/12 – 4/5/13), eight months (7/23/14 – 3/31/15), and one year and four months (4/13/15 – 8/22/16).

After his review of the medical records, including treating records prior to the alleged date of accident and records after the alleged accident, as well as his examination of the Petitioner, Dr. Walsh found that Petitioner's objective findings were degenerative in nature and that, at most, Petitioner sustained a shoulder strain for which he had reached MMI and was capable of returning to work full duty without restrictions. (Rx. 3).

Pursuant to his IME exam of Petitioner in July of 2015, Dr. Walsh again opined that Petitioner's subjective complaints were disproportionate to the objective findings. Further, Dr. Walsh's report noted Petitioner's excessive Norco and Vicodin usage, which Petitioner alleged was related to his right shoulder condition stemming from 2012. However, this Arbitrator notes that Petitioner was taking the Norco and Vicodin in relation to his chronic low back pain, not his right shoulder condition. Dr. Walsh again opined that Petitioner's condition of ill-being was not related to his alleged work accident in 2012.

After careful consideration of the evidence contained in the record, the Arbitrator concludes that Petitioner's condition of ill-being is not causally related to the alleged date of accident on 9/12/12. The Arbitrator finds that, at most, Petitioner sustained a sprain/strain of the right shoulder that resolved no later than 12/10/12. The Arbitrator finds that any treatment after December of 2012 is not causally related to the 9/12/12 incident.

Medical Bills

As stated above, The Arbitrator finds that Petitioner's condition of ill-being is not causally related to the accident date of 9/12/12 and, at most, Petitioner sustained a sprain/strain of the right shoulder that resolved no later than 12/10/12. Therefore, the Arbitrator finds that the Respondent is not liable for any alleged outstanding medical bills after 12/10/12.

Further, according to Petitioner's Exhibit 13, the Arbitrator notes that a number of the alleged outstanding medical bills are related to Petitioner's treatment for his right knee condition. The Arbitrator finds that Petitioner's right knee condition is unrelated to Petitioner's 9/12/12 condition. The Arbitrator questions why those bills were submitted into evidence and claimed as outstanding bills when Petitioner admitted that his right knee condition was *not causally related* to the 9/12/12 alleged accident. The Arbitrator finds that any outstanding bills relating to the right knee are not the Respondent's liability.

TTD

As noted above, the Arbitrator finds that Petitioner's condition of ill-being is not causally related to the alleged date of accident on 9/12/12 and, at most, Petitioner sustained a sprain/strain of the right shoulder that resolved no later than 12/10/12. Accordingly, Petitioner's claim for TTD benefits, which claim entitlement to TTD benefits after 12/10/12, is denied.

Prospective Medical

As noted above, the Arbitrator finds that Petitioner's condition of ill-being is not causally related to the alleged date of accident on 9/12/12 and, at most, Petitioner sustained a sprain/strain of the right shoulder that resolved no later than 12/10/12. Accordingly, his claim for prospective medical treatment is denied.

Penalties and Fees

The Arbitrator declines to award any penalties or fees in this matter. The Arbitrator finds that the Respondent did not act vexatiously or frivolously in denying benefits. The Arbitrator finds that the Respondent acted reasonably in denying benefits based on the medical records, the gaps in medical treatment and the expert opinions of Dr. Walsh. (Rx. 3; 4).

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

Stacy Mickelson,
Petitioner,
vs.

NO: 14WC 16774

State of Illinois /
Murray Center,
Respondent,

18IWCC0375

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 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 January 9, 2018 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JUN 12 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/rlc
d060618
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

MICKELSON, STACY
Employee/Petitioner

Case# **14WC016774**

SOI/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

18IWCC0375

On 1/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.57% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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THOMAS C RICH
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0502 STATE EMPLOYEES RETIREMENT
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1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JAN 9 - 2018

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

18IWCC0375

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
CORRECTED ARBITRATION DECISION
NATURE AND EXTENT ONLY

STACY MICKELSON
Employee/Petitioner

v.

STATE OF ILLINOIS/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

Case # **14** WC **16774**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **June 7, 2017**. By stipulation, the parties agree:

On the date of accident, **August 23, 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 $**31,410.63**, and the average weekly wage was $**766.11**.

At the time of injury, Petitioner was **36** years of age, ***married*** with **1** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of $459.67/week for a further period of 125 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused 25% loss of use of the person as a whole.

Respondent shall pay Petitioner compensation that has accrued from November 22, 2016, through June 7, 2017, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

January 9, 2018
Date

JAN 9 - 2018

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

18IWCC0375

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
NATURE AND EXTENT

STACY MICKELSON
Employee/Petitioner

v.

Case #: 14 WC 16774

STATE OF ILLINOIS/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on August 23, 2013, Petitioner sustained an accident which arose out of and in the course of her employment with Respondent. The parties stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability.

On the date of accident, Petitioner was 36 years old, married, and had one dependent child. She was employed as a Support Service Worker in Respondent's Murray Developmental Center, and had been so employed since 2002. On that date she was helping unload a truck and a large metal cabinet fell on her, injuring her low back. Petitioner acknowledged during testimony that she had previously undergone a microdiscectomy as a result of a prior work injury. She testified she had been working full duty without restrictions at the time of the most recent accident.

On August 26, 2013, Petitioner completed an Employee's Notice of Injury. She indicated she was unloading a truck when a large metal cabinet fell apart and hit against her side and landed on her foot. She indicated this caused her to jar her lower back and she experienced pain and a burning sensation across her lower back and into her left leg and foot. RX1.

Following the accident, Petitioner presented to Dr. Todd Stewart of Neurological Surgery on September 11, 2013. It was noted that she reported "that she has had constant left-sided low back pain since her last visit in July". She further reported a consistent history of the accident on August 23, with complaints of more severe pain in her left low back and now extending down her lateral leg to the bottom of her foot. It was noted the pain had been on the left side in the past but now was on the right side of her low back as well. Physical examination was markedly positive, with findings of positive straight leg raise bilaterally. Dr. Stewart ordered an MRI and referred Petitioner to Dr. Hurford for injections. PX3.

On October 14, 2013, Petitioner presented to Dr. Adam LaBore at Washington University Orthopedics. It is unclear whether this was a referral. Dr. LaBore's record referenced a work injury of January 5, 2012, but did not reference the more recent injury of August 23, 2013. Petitioner reported chronic numbness throughout her left thigh, calf, foot, and toes. Dr. LaBore diagnosed left sacroiliac joint dysfunction and recommended an SI joint injection. PX4.

On October 16, 2013, Petitioner underwent a lumbar MRI which revealed (1) metal distortion artifact, left L4 foramen, suspicion that there is a protrusion into the left L4 foramen but no definite left L4 root compression; and (2) left more evidence than right L4-5 facet joint inflammatory changes. PX5.

Petitioner returned to Dr. Stewart on October 25, 2013. He reviewed the MRI and recommended a CT scan. PX3. Petitioner underwent the lumbar CT on November 8, 2013. It revealed (1) no evidence of metallic object or artifact at any location; and (2) soft tissue fullness arising from or adjacent to the L4-5 disc in the left neural foramen. PX6.

On December 13, 2013, Petitioner underwent an SI transforaminal epidural steroid injection by Dr. LaBore. PX4.

On January 9, 2014, Petitioner returned to Dr. Stewart and reported she had undergone a left L4-5 selective nerve root injection which gave her about two weeks of relief. Lumbar x-rays and MRI were reviewed, which showed a far lateral disc herniation at L4-5 and evidence of a previous laminotomy at L4-5. Dr. Stewart recommended a far lateral discectomy at L4-5 on the left. On February 7, 2014, Petitioner called Dr. Stewart to discuss her surgical options. It was decided she would undergo a fusion at L4-5. PX3.

On March 20, 2014, Petitioner was evaluated by Dr. Frank Petkovich, Respondent's Section 12 examiner. Dr. Petkovich performed a physical examination and reviewed Petitoner's medical records. He diagnosed Petitioner with a disc herniation at left L4-5, with compression of the left L4 nerve root. He agreed with the recommended surgery and opined that the herniation and need for surgery were causally related to Petitioner's work injury of August 23, 2013. RX4.

On March 28, 2014, Petitioner underwent surgery by Dr. Stewart and Dr. Robson, which consisted of an L4-5 lumbar decompression and posterior lumbar interbody fusion. She followed up with Dr. Stewart on April 30, 2014, and reported she had complete relief of her leg pain. It was noted she was doing very well post-surgery and had relief of her radicular symptoms. Petitioner returned to Dr. Stewart on July 7, 2014, and advised she had relief of her leg symptoms but complained of left buttock pain. It was noted she had left sacroiliac joint disease and would benefit from an evaluation by Dr. LaBore. On August 20, 2014, Petitioner followed up with Dr. Stewart and continued to complain of symptoms of SI joint disease. Dr. Stewart recommended facet joint injections and allowed Petitioner to return to light duty work as of August 25, 2014. PX3.

On August 22, 2014, Petitioner returned to Dr. Petkovich for a second Section 12 examination. After performing a physical examination and reviewing updated medical records, Dr. Petkovich diagnosed Petitioner with lumbar disc herniation at L4-5, pain in the left thigh area, pain and numbness in the left foot area, and pain over the sacroiliac joint area. He indicated that

Petitioner's pain and numbness in her left foot and thigh had resolved, but she still had discomfort over the sacroiliac joint. Dr. Petkovich opined that Petitioner's work injury of August 23, 2013, had irritated her left sacroiliac joint area and he recommended SI joint injections. RX5.

On October 15, 2014, Petitioner underwent left sacroiliac joint injection under fluoroscopy by Dr. LaBore. She followed up with him by phone following the injection and reported no improvement. He prescribed Gabapentin at that time. Petitioner returned to Dr. LaBore on December 10, 2014, who noted that the Gabapentin had helped reduce and localize symptoms to one small area. On examination, she continued to have pain in the SI and hip areas. She was instructed to continue use of the Gabapentin and to increase to three times a day. PX4.

On January 7, 2015, Petitioner followed up with Dr. Stewart and advised she felt worse after the SI injections. Lumbar x-rays showed a solid fusion. She was referred to physiatry for treatment of the left SI joint pain and was continued on work restrictions placed by Dr. Petkovich. Petitioner returned to Dr. Stewart on April 8, 2015, and reported continued SI joint pain. Lumbar x-rays showed a solid fusion. Dr. Kennedy noted Petitioner had done remarkably well with resolution of her axial back pain and radiculopathy after her fusion, and that her remaining sole problem was her left sacroiliac joint disease. Petitioner advised she wanted a second opinion regarding her SI joint, and was referred to physiatry at Orthopedic Associates. PX3. The Arbitrator notes the record is silent as to whether this second opinion occurred.

Petitioner followed up with Dr. Stewart on June 10, 2015. She denied any leg pain, numbness, tingling, or mid-back pain. She continued to report left SI joint pain and posterior buttock pain. Dr. Stewart noted "She is doing remarkably well from her lumbar decompression and fusion with relief of her back and leg pain." He further noted Petitioner had left sacroiliac joint disease, a condition which he does not treat. He again recommended she be evaluated by physiatry for management of her SI pain. PX3.

On August 4, 2015, Petitioner presented to Dr. Davis Raskas of Orthopedic Sports Medicine & Spine Care Institute. Dr. Raskas noted a consistent history of the accident and Petitioner's persistent complaints of left sided to central low back pain radiating into her left hip and lateral leg. He noted Petitioner had been working light duty up until March 5, 2015, at which time Respondent ceased providing accommodations. On examination, there was tenderness to palpation over the posterior superior iliac spine. Dr. Raskas recommended SI joint blocks done twice and a CT scan, with the possibility of a discogram. Petitioner underwent the SI joint injection that day, which relieved her pain. PX10.

On August 12, 2015, Petitioner underwent a pelvic CT which revealed mild bilateral sacroiliac joint osteoarthritis and changes of prior instrumented lumbar fusion at L4-5. She also underwent a lumbar CT which revealed postoperative changes at L4-5 with a solid fusion, degenerative changes and bulge at L5-S1, and mild scoliosis. PX11.

Petitioner followed up with Dr. Stewart on August 12, 2015, and reported her recent evaluation by Dr. Raskas and SI injection, which provided relief for about 30 hours. She denied any back pain or radicular leg pain. Dr. Stewart noted she was doing extremely well from her spine standpoint, with complete relief of her back pain and radicular leg pain. Petitioner was to

continue treatment with Dr. Raskas for her SI joint disease. She was allowed to work with restrictions of no lifting over 35 pounds, and only occasional bending, twisting, stooping, pushing, or pulling. She was to return in six months for re-evaluation. The Arbitrator notes this was the final record from Dr. Stewart. PX3.

On August 14, 2015, Petitioner returned to Dr. Raskas, who reviewed the results of her CT scans. Given the findings and Petitioner's continued complaints, Dr. Raskas believed she was a candidate for a left SI joint fusion. Petitioner agreed with the recommendation. She underwent a second SI joint injection by Dr. Wayne at that time. PX10.

On September 2, 2015, Petitioner underwent a left SI joint percutaneous fusion with instrumentation and local autograft and allograft, performed by Dr. Raskas. PX13. She followed up with Dr. Raskas on September 18 and reported pain in the area of her incision. She was prescribed an oral steroid to reduce the inflammation. PX10. She underwent a pelvic CT on October 7, 2015, which was negative for fracture. PX16. She returned to Dr. Raskas on October 19 and reported she was walking better and only using Flexeril for pain relief. Dr. Raskas reviewed the CT scan, which showed hardware to be in good position. Petitioner was to remain off work and follow up in 12 weeks for a repeat CT scan. PX10.

On November 13, 2015, Petitioner returned to Dr. Petkovich for an additional Section 12 examination. Following a physical examination and review of additional records, Dr. Petkovich opined that the medical treatment Petitioner had received thus far was reasonable, appropriate, and causally related to her work accident of August 23, 2013. He agreed with the recommended CT and follow up care with Dr. Raskas. RX6.

On January 21, 2016, Petitioner underwent a pelvic CT. It revealed (1) arthrodesis of the left sacroiliac joint without osseous fusion in the joint; (2) anterior interbody and posterior fusion with laminectomy of L4-5, no appreciable solid osseous fusion within the L4-5 joint space, no evidence of hardware loosening or displacement; (3) disc bulge at L5-S1 with facet arthropathy resulting in left mild to moderate foraminal stenosis; and (4) no acute fractures. PX17.

Petitioner followed up with Dr. Raskas on January 22, 2016, and reported she was doing very well with only intermittent left-sided back and buttock pain. She indicated she took no medications except an occasional Flexeril. Dr. Raskas obtained x-rays, which showed the screws to be in good position with no evidence of hardware loosening or failure. He also reviewed the CT scan and noted that the screws were in good position and that, although the fusion was not yet solid, the hardware was stable. Petitioner was allowed to return to work with restrictions of no lifting greater than 15 pounds and no bending, twisting, or stooping. PX10.

On March 18, 2016, Petitioner returned to Dr. Raskas and reported she was "doing wonderful" and felt "markedly better than she did prior to the SI joint fusion". It was noted she was not currently working, as of March 5, 2016, as her employer no longer had light duty available. Examination was normal and x-rays showed the screws were in good position with no loosening of hardware. Dr. Raskas recommended a course of work conditioning followed by a Functional Capacity Evaluation. PX10.

Petitioner underwent physical therapy at Apex from March 29 through April 15, 2016, and underwent an FCE on April 18, 2016. The FCE concluded she was able to perform in the medium physical demand level. PX18.

On May 10, 2016, Petitioner returned to Dr. Raskas, who reviewed the results of the FCE with her. Based on the FCE and her physical examination, Dr. Raskas released her to return to work with a 50-pound lifting restriction. Petitioner followed up on June 21, 2016, nine months post-op, and reported she was doing remarkably well, with 80-90% improvement from prior to surgery. She advised she was functioning well at work within her restrictions and was not using any significant amount of pain medication. Examination was normal, and x-rays showed good screw placement and a solid fusion. Petitioner was to continue with work restrictions. PX10.

Petitioner underwent a pelvic CT on June 29, 2016, which showed arthrodesis of the left sacroiliac joint, without appreciable osseous fusion in the joint space. PX17. She followed up with Dr. Raskas on September 20, 2016, and reported she felt remarkably better. Her pain level at its worst was 2/10 and she did not have to take pain medication on a regular basis. She indicated she was working regular duties without restrictions. PX10.

On November 22, 2016, Petitioner underwent a repeat pelvic CT, which showed no evidence of hardware failure or abnormal migration. It was noted, however, that the fusion was not solid. Petitioner also underwent a lumbar CT, which showed the previous decompression and instrumentation at L4-5. It was noted that the fusion did not appear to be solid. PX17.

Petitioner followed up with Dr. Raskas following the CT scans on November 22. She reported she was doing well but experienced buttock pain when she sat for prolonged periods of time. Dr. Raskas reviewed both CT scans and noted the lack of complete fusion in both areas. Despite the findings, he opined that Petitioner was doing very well clinically and there was no evidence of hardware failure. He placed her at maximum medical improvement and released her from care on an as needed basis. PX10. The Arbitrator notes this is the final treatment record.

Petitioner entered into evidence her CMS Promotional Employment Application, which showed her position titles during the course of her employment for Respondent. Those position titles included: mental health technician trainee (3/2002-12/2002); mental health technician I (12/2002-1/2004); mental health technician II (1/2004-1/2008); support service worker—dietary (1/2008-8/2013); support service worker—housekeeping (8/2013-7/2016); support service worker—laundry (7/2016-8/2016); support service coordinator II—temporary assignment (8/2016-4/2017); and support service worker—laundry (4/2017-5/2017). PX19.

Petitioner testified at hearing that her condition improved with her surgeries and extensive physical therapy. Despite the improvement from surgery, she continues to experience symptoms depending on her level of activity. She testified that she continues to have an unrelenting cramping sensation in her left hip and buttock initiated by certain activities. She testified that when certain activities cause it to flare "it doesn't go away", and that this is the worst symptom she has because "once it hits, it's [there] until the next morning". She testified that it is brought about by twisting, lifting, and sitting in chairs lacking adequate support. She takes Tramadol for her symptoms about twice a week. Her Petitioner's hobbies of horseback and motorcycle riding have been eliminated

as a result of her injury. Her sleep has also been adversely affected. She testified that if she sleeps for longer than 6 hours, she will become so stiff that she will be unable to get up. She also has to take Unisom to help her to sleep. Petitioner testified she attempted to return to work as a housekeeper, but was unable to bend and twist. She was then transferred to a support laundry position, where she does not have to work below her waist level. She suffered no loss in earnings as a result of this transfer.

On cross-examination, Petitioner acknowledged she was currently back to work full duty with no restrictions. She is not currently seeing a doctor for her condition and is not undergoing physical therapy. She is not required to wear any type of brace or protective device. She is able to perform her job satisfactorily and has not had any complaints from her supervisors regarding her job performance. Petitioner acknowledged she had a previous work injury in 2012, for which she underwent surgery by Dr. Gornet at the L4-5 level. She did not dispute that she had seen Dr. Stewart in July 2013 for an evaluation of her lower back pain.

Respondent called Jeff Frost as a witness. Mr. Frost testified he is employed at Murray Developmental Center as a business manager, temporarily assigned as the business administrator. He has been employed by Respondent for over six years. Mr. Frost testified he is familiar with Petitioner, as he supervises her department. He testified that Petitioner's current title is a support service worker in housekeeping and noted that a person in her position could be assigned to laundry. He did not know where she is currently assigned, but her position number in her personnel file indicates she is a support service worker in housekeeping. He testified laundry falls under the housekeeping unit.

On cross-examination, Mr. Frost testified Petitioner is currently performing the job duties of laundry. He was asked if anything Petitioner said was untrue, and he testified the only thing was that her position number is in housekeeping. He reviewed Petitioner's Exhibit 19, which he testified showed Petitioner was in laundry.

On redirect, Mr. Frost testified that while laundry has its own direct supervisor, laundry does fall under housekeeping. He testified that Petitioner's Exhibit 19 does not list any reason for a position switch, and that it is common for a form like this to be completed regardless of the reason for the switch in positions.

Petitioner was recalled as a witness. She testified that Petitioner's Exhibit 19 is a promotional application for the Support Service Coordinator I position which manages laundry and housekeeping. She acknowledged that it lists all of the positions she has had while employed by Respondent and that it does not list a reason she switched positions.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The only issue in dispute at the time of hearing was the nature and extent of the permanent partial disability. With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011,

pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

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

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Support Service Worker in housekeeping at the time of the accident and that she was able to return to work in that capacity without any restrictions or limitations as a result of said injuries. Petitioner testified that following her return to work she transferred to a different position, in the laundry area, that does not require her to twist or bend. Mr. Frost testified, however, that Petitioner's position continued to be Support Service Worker and that laundry came under the housekeeping area. The Arbitrator places significant weight on the fact that Petitioner was released to return to work without restrictions and thus places significant weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 36 years old at the time of the injury. She is a younger individual and has many working years during which she must live with the effects of her injury and surgeries. Over time her condition could improve, stay the same, or get worse. The Arbitrator gives greater weight to this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner returned to her prior position full duty. There was no evidence that her future earning capacity has been or will be impacted as a result of this injury. As such, the Arbitrator gives no weight to this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes that Petitioner sustained injury to her lumbar spine with SI joint dysfunction which failed to improve with conservative measures. She ultimately required two surgeries, a posterior lumbar fusion with laminectomy and foraminotomy at L4-5, and a sacroiliac joint fusion. Petitioner testified she continues to experience symptoms, depending on her level of activity, and that she continues to have an unrelenting cramping sensation in her left hip and buttock with certain activities. She takes Tramadol as needed for symptoms. Her sleep patterns and hobbies have been impacted. Petitioner's complaints are well-documented throughout her treatment. Dr. Raskas noted in his final treatment record that neither the lumbar nor the SI fusion had solidly fused yet, but otherwise noted that Petitioner had achieved a good result. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained 25% loss of use of the person as a whole (125 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $766.11. The Arbitrator finds her permanent partial disability rate is $459.67.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Sizemore,
Petitioner,
vs.

NO: 13WC 20798

State of Illinois Department of Juvenile Justice / Illinois Youth Center,
Respondent,

18IWCC0376

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, 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 14, 2016 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JUN 13 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/rlc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SIZEMORE, ROBERT
Employee/Petitioner

Case# **13WC020798**

ST OF IL DEPT OF JUVENILE JUSTICE/ILLINOIS YOUTH CENTER
Employer/Respondent

18IWCC0376

On 11/14/2016, 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 0.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2546 FEIST LAW FIRM LLC
ROBERT KUPPART
617 E CHURCH ST SUITE 1
HARRISBURG, IL 62946

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

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

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

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

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

NOV 14 2016

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

18 IWCC0376

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

ROBERT SIZEMORE
Employee/Petitioner

v.

STATE OF IL. DEPT. OF JUVENILE JUSTICE / IL. YOUTH CENTER
Employer/Respondent

Case # **13** WC **20798**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **June 16, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0376

FINDINGS

On **April 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 **$80,316.00**; the average weekly wage was **$1,544.54**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **1** dependent children.

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

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

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

ORDER

The Petitioner proved he sustained accidental injury arising out of and in the course of his employment on **April 21, 2013**. The Petitioner also proved that his left shoulder injury and need for surgery is causally related to the **April 21, 2013** accident.

Respondent shall pay Petitioner temporary total disability benefits of **$1,029.69** per week for **25-4/7 weeks**, commencing **August 20, 2015 through February 14, 2016**, as provided in Section 8(b) of the Act.

Respondent shall pay the **reasonable and necessary causally related medical services that are reflected in Petitioner's Exhibit 13**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any medical benefits that had been paid prior to the June 16, 2016 hearing, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit.

Respondent shall pay Petitioner permanent partial disability benefits of **$712.55** per week, the maximum allowable rate, for **57.5 weeks**, because the injuries sustained caused the **11.5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act, with regard to the Petitioner's left shoulder injury.

Respondent shall pay Petitioner compensation that has accrued from **April 21, 2013** through **June 16, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

October 24, 2016
Date

ICArbDec p. 2

NOV 14 2016

STATEMENT OF FACTS

The Petitioner was employed by the Respondent as a juvenile justice specialist. On 4/21/13, there was a disturbance in Unit 4 where juvenile inmates were trying to break the windows out of the rooms. One inmate would not stop and had to be taken to confinement. The Petitioner went into the cell to handcuff him, the inmate charged him and: "swung at me, hit me like chest, shoulder area on my left shoulder." He grabbed the inmate and they continued to wrestle until the Petitioner got control of the inmate face down on the bed. The Petitioner had one of the inmate's arms behind his back while another officer had the other arm, and they restrained him and escorted him out. The Petitioner didn't specifically recall striking his shoulder, but testified everything happened fast, they were in a small cell and they were on the floor, against walls and on the bed during the altercation.

The Petitioner testified he didn't notice any immediate pain and soreness. While completing accident report paperwork, he noticed his left shoulder was tender and that he had hurt it, but it didn't seem like anything major. He couldn't say if he indicated a left shoulder injury in the accident documentation. The Form 45 (Rx1), dated 4/22/13, states the following: "EE states that while responding to call/entered a youth cell; youth ran towards him and hit him in his chest; EE had to wrestle the youth onto his bed/against the cell wall; EE unsure of where he hit his left shoulder." An incident report, dated 4/23/13 and noting the report was made on 4/22/13, states the Petitioner's left shoulder had not stopped hurting since the 4/21/13 altercation. (Rx1).

A "Supervisor's Report of Injury or Illness", dated 5/8/13. Indicated the Petitioner responded to a disturbance on Unit 4, was instructed to restrain an unruly youth, and injured his left shoulder. This document also noted it was reported on 4/22/13. (Rx1). A "Workers' Compensation Employee's Notice of Injury", also dated 5/8/13, signed by Petitioner, states: "My shoulder was not hurting at the time of the incident. It was by early next morning." The rest of this report was consistent with the Petitioner's testimony regarding the incident. (Rx1). Witness Susan Prince prepared a report indicating the Petitioned was charged by the inmate, "pushed him with force in the chest area knocking (Petitioner) against the wall." (Rx1). A witness statement from Karen Mace noted the inmate ran towards the Petitioner with his fist, striking Petitioner in the chest with great force and knocking him backwards into the wall. It further noted that the Petitioner and another worker, Miller, had to restrain the inmate, and that the inmate had also swung his fists at Petitioner's face. (Rx1).

The Petitioner testified that he had prior work injuries involving his right hand, right shoulder and his knee, and he had not made workers compensation claims for any of them. He noted the right shoulder injury also had occurred during an altercation at work. He hoped it would go away and didn't immediately seek treatment, and

it resolved after three to four weeks. The Petitioner testified that he did the same thing in this case, hoping the left shoulder symptoms would resolve, but he instead continued to worsen.

The Petitioner initially sought treatment on 5/14/13 with his primary care provider, Dr. Partridge. The visit was for diabetes treatment, but the Petitioner reported a 4/21/13 injury, and that he had been performing activities at home and had worsened to where he couldn't work on 4/27/13. An x-ray was prescribed, and the Petitioner followed up on 5/21. At that time he reported the specifics of the alleged accident, indicating he was shoved by an inmate and then had to wrestle with him, ending up with left shoulder pain. He noted he continued to worsen after that, and had pain with things like throwing a softball or sleeping on the left side. He reported no prior left shoulder problems. He also reported shooting pain and numbness. Dr. Partridge diagnosed a shoulder strain/sprain and prescribed physical therapy and medication, noting an MRI would be indicated if Petitioner failed to improve in a month to rule out internal derangement. The report noted the Petitioner did miss a day of work on the 27th "which he had exacerbated things doing yard work that he normal was used to." (Px1).

On 7/1/13, Dr. Partridge noted Petitioner had some improvement while he was off work on vacation, but that symptoms were ongoing. The report indicated the Respondent would not authorize physical therapy, and that Petitioner, in consultation with his attorney, wanted an MRI, which Dr. Partridge agreed was indicated. The 7/3/13 MRI films reflected AC joint degeneration, but were otherwise unremarkable. (Px2; Px3; Px7).

On 7/10/13, the Petitioner reported he was caught between his workers compensation and group health coverage, because each was claiming his treatment was the other's responsibility. He was referred to an orthopod in Herrin, Illinois. On 8/21/13, the Petitioner reported he was having difficulty getting in to see an orthopedic specialist, and that he was continuing to get worse. It appears there was no further treatment until he returned to Dr. Partridge on 3/18/15, reporting 3 out of 10 pain, worse with activity. The diagnosis was tendonitis, and he was again referred for an orthopedic consultation. (Px3; Px7).

The Petitioner testified that it took some time for medical work up and treatment to proceed in a timely fashion because the Respondent had denied his claim. He testified that he continued to have pain in the left shoulder from the time of the accident until he got in to see Dr. Davis. He did continue working during that time. While trying to play softball, do yard work, etc., he would notice the pain would increase.

On 4/1/15, the Petitioner saw orthopedic surgeon Dr. Davis. He reported that after an altercation at work, he developed shoulder pain that night which continued to worsen thereafter, and that he initially sought treatment a few weeks after the incident. He reported continuous pain since that time, and that workers compensation had denied the claim. Dr. Davis examined the Petitioner and reviewed the x-ray and MRI, and diagnosed biceps and rotator cuff tendinosis with possible underlying labral sprain versus occult tear. He opined that the Petitioner's left shoulder condition was related to the 4/21/13 incident, and prescribed physical therapy as the Petitioner had not yet undergone any conservative treatment beyond medication. If that did not help, he recommended an injection, and if that didn't work an MRI would be obtained to determine if surgery was appropriate. (Px4; Px7).

Petitioner underwent therapy from 4/6 to 4/29/15, which Petitioner testified did not help at all. (Px6), and Dr. Davis injected the shoulder on 5/7/15. (Px7). On 6/24/15, the Petitioner reported good relief with the injection and felt he could live with the shoulder as it was at that time. (Px7). The Petitioner testified that after about 2 weeks, the shoulder went back to the way it was before the injection. Petitioner returned to Dr. Davis on 8/5/15, indicating he was tired of living with his symptoms and that he wanted to undergo surgery. (Px8).

Dr. Davis performed surgery on 8/20/15. The post-surgical diagnoses were: 1) partial thickness rotator cuff tear, 2) biceps tendinopathy, 3) subacromial outlet impingement, 4) degenerative labral fraying and 5)

subacromial/subdeltoid adhesions. Arthroscopic surgery included cuff repair, subacromial decompression, debridement of partial thickness supraspinatus tendon tear, residual biceps tendon stump, degenerative labral tearing and the adhesions. Open subpectoral biceps tenodesis was also performed. (Px9).

Petitioner participated in post surgical therapy from 9/2/15 through 2/12/16, and remained off work. (Px12). Dr. Davis' records indicate the Petitioner reported consistent progress. His last report of 2/10/16 indicates the Petitioner was still a little sore and stiff, but felt he was continuing to improve, and he released the Petitioner to full duty as of 2/15/16. (Px10). The therapy discharge report from 2/12/16 noted the Petitioner had 56 visits, but that he still had not reached all of his pre-therapy goals. (Px12).

The Petitioner testified his shoulder felt okay when he went back to work. Though he had some ongoing pain, it didn't impact his ability to do perform his work duties. He has soreness and pain at almost all times, but does not take any medication. His pain is the worst when he does too much activity, like mowing or weed eating, cleaning the pool, washing his vehicle, etc. He testified he stopped playing sports like golf, basketball, volleyball, and practicing softball with his daughter.

On cross examination, Petitioner agreed he is a type II diabetic, which was diagnosed three or four years prior to the hearing, and agreed that the 5/14/13 visit with Dr. Partridge had been a scheduled diabetes follow-up. He also agreed that the 2013 MRI did not disclose any tears, and that he didn't see Dr. Davis until almost two years after the 4/21/13 incident. He testified that Dr. Davis didn't order a new MRI because he figured it would not be authorized.

The Petitioner testified that he washed cars for pay as a hobby, approximately 1-2 per week, and that he did wash cars in the week or two after the 4/21/13 incident. He also testified, however, that he did not recall telling the Respondent's workers compensation coordinator, Terri Reed, that he had shoulder pain while washing cars.

He Petitioner testified that he called and reported the injury during the day shift the day after he got hurt, and the supervisor he spoke to indicated he should complete paperwork when he came in for his night shift. He doesn't know if he specified in the reporting documents that he got hit in the shoulder, or if he just said he got hit in the chest.

Respondent's workers compensation coordinator, Terri Reed, testified on behalf of the Respondent. She indicated that, in her role, she receives calls from workers compensation claimants and speaks to them quite often. She testified that the Petitioner called on 4/22/13, the day after the injury, indicating that he was fine and didn't see any problems, but that he wanted to make sure he had a report on file. She asked him if he went to Respondent's medical provider, which is normal protocol, and the Petitioner said that he hadn't.

She testified that the Petitioner called her the week of 5/9/13, indicating he wanted to complete and submit his injury paperwork "because during the time of practicing softball with his daughter and managing a detailing business and washing cars, that he felt his shoulder did not feel quite right and thought that he needed to see a physician." She testified that she implemented the process of having him see a physician, but that he asked to just see his family physician on May 14th when he was scheduled for a diabetes checkup.

With regard to Rx1, she herself didn't sign any of the paperwork contained therein, but she testified that she did note the conversations with Petitioner for her file via emails between her and the Petitioner's supervisor. However, she agreed that the emails were not submitted as part of Rx1. Ms. Reed testified that the Petitioner did call into Tristar, apparently Respondent's workers compensation vendor, at the time of the accident, and completed an incident report with his supervisor two days later, but that the paperwork wasn't signed by

Petitioner or turned in to her until 5/8/13. She also testified that when the Petitioner called on 5/9, she emailed Tristar to document the conversation and to let them know he was turning in his paperwork and going to see his doctor on 5/14/13.

Dr. Davis, a board certified orthopedic surgeon specializing in shoulders, elbows and knees, testified on 5/26/16. (Px11). He testified that his examination on 4/1/15 reflected tenderness on the front of the shoulder at the bicep area, some impingement signs and an aggravation of pain with pinching against the rotator cuff. He indicated the 2013 left shoulder MRI showed some signal along the long head of the biceps which suggested tendinosis, along with rotator cuff tendinosis, but that: "it really didn't offer a lot. It wasn't the best quality." (Px11, p. 8). Dr. Davis opined within a reasonable degree of medical certainty that, based on his stated history of the work injury, the Petitioner's left shoulder condition was causally related to his work injury of 4/21/13. He further opined that the condition in Petitioner's shoulder could worsen over time, and that daily activities and work activities can progress such an injury to the joint. (Px11).

Dr. Davis noted that the Petitioner's relief with an injection to the front of the shoulder was indicative of pain being generated from that area. When further conservative treatment failed, given the time that had passed, he offered the Petitioner surgery, which was performed on 8/20/15. He testified this involved rotator cuff (subscapularis) repair, subacromial decompression and detachment and reattachment of the bicep tendon. (Px11). While the MRI hadn't indicated a tear, Dr. Davis indicated that the surgical procedure that he performed confirmed his diagnosis regarding the bicep and the bone spur, and testified specifically: "It's not uncommon particularly in these patients that have pain in the front part of the shoulder to see damage to that front rotator cuff and then the subscapularis tendon, but it's sometimes difficult to see on MRI scan or ultrasound, and that was the case with him. The tendon was torn and more to the point where he needed a stitch." (Px11, p.11-12). Dr. Davis further testified that the surgery was also causally related to the 4/21/13 work accident. The Petitioner was held off work post-surgery, and he last saw him on 1/25/16. Dr. Davis did issue a 3/10/16 work status report which allowed the Petitioner to return to unrestricted work duties as of 3/15/16. (Px11).

On cross examination, Dr. Davis testified that the indication of a complete traumatic rotator cuff tear in his 1/25/16 note was a typographical error, and that there was no complete tear found during surgery. Dr. Davis testified that there is no way to tell if the type of tear the Petitioner had was traumatic by looking at it with no other history or examination. Based on the Petitioner's history of not having pain before the accident and having it afterwards, and of him having an actual tear found at surgery that corresponded to his pain complaints, he believed that the tear was causally related to the accident. Dr. Davis did agree that tears can be degenerative or have hereditary factors, and that the Petitioner had diabetes, but he opined that diabetes in and of itself would not cause a cuff tear. He also agreed that any traumatic insult could cause an injury like the Petitioner had, including washing a car. (Px11).

The Petitioner submitted the medical expenses he alleges are causally related to this claim as Petitioner's Exhibit 13.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner sustained an accidental injury arising out of and in the course of his employment with the Respondent on 4/21/13.

On that date, he was involved in an altercation with an inmate who attacked him while he was in the course of restraining the inmate to bring him to a confinement area. The Respondent has presented no evidence which would indicate that this incident did not occur. The Petitioner reported the incident the same day, and investigatory documentation was prepared, including multiple witness statements which support the incident occurring as the Petitioner has testified.

The Arbitrator finds that the evidence supports the finding of a compensable 4/21/13 accidental injury to the Petitioner.

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

The Arbitrator also finds that the Petitioner's left shoulder condition is causally related to the 4/21/13 accident.

The documentation that was done at the time of the accident references a left shoulder injury. While it is true that the Petitioner could not say exactly how the injury occurred, he was quite clear that something happened to the left shoulder during the 4/21/13 altercation with the unruly inmate who attacked him. Using a chain of events analysis, and given that there is no evidence that the Petitioner had a preexisting injury, the Arbitrator finds that a left shoulder injury occurred on 4/21/13.

The Arbitrator understands the basis of the Respondent's defense in this case, that being the significant gap in time between the Petitioner's 8/21/13 and 3/18/15 visits with Dr. Partridge, while he continued to work full duty. This is a significant period of time during which the Petitioner very easily could have injured the shoulder further. Additionally, the 2013 MRI was noted to be normal, and not indicative of a tear.

However, the Arbitrator believes that there were other factors at play which leads to the conclusion that the left shoulder condition remained causally related to the 4/21/13 accident. First, the Arbitrator noted that the Petitioner appeared to be credible and consistent during his testimony. Additionally, the Petitioner testified that he was having trouble getting treatment at various times due to the Respondent's denial of the claim. While it appears that he had group health insurance coverage, he also testified that both that insurer and the workers compensation carrier were each arguing that the other carrier was responsible for coverage. The records reflect the Petitioner had an orthopedic referral from Dr. Partridge in 2013. Further, the Arbitrator finds the testimony of Dr. Davis to be persuasive in this case. His testimony regarding the poor quality of the MRI and how the tear could have existed at the time the films were obtained makes sense to the Arbitrator. Much of what was seen and repaired in the shoulder outside of the tear involved some level of degeneration, including adhesions, which could have been due to an injury that occurred on 4/21/13.

Clearly the Petitioner was performing some significant ongoing activities between 8/21/13 and 3/18/15, which included not only his work duties, but also appears to have included softball with his daughter and washing cars. However, the injury itself does not appear to be of the kind that was emergent, as it was only a partial cuff tear, and it instead appears to be of the nagging variety. Dr. Davis was the only surgical physician involved in this case, and his opinion that the left shoulder condition remained causally related to the 4/21/13 accident was unrebutted. The Arbitrator also again notes the issue with getting his treatment covered to some degree during this time.

Taking all of the evidence as a whole in this particular case, the Arbitrator believes that the greater weight of the evidence supports a finding that the Petitioner's left shoulder condition was and remained causally related to the 4/21/13 accident.

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

The Arbitrator finds that the Petitioner is entitled to payment by the Respondent of the medical expenses submitted in Px13. The Respondent is entitled to credit for any of the awarded medical expenses that were paid in full, either per the fee schedule or per other agreement, prior to the hearing date.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that, based on the evidence indicated above, the Petitioner was temporarily and totally disabled from 8/20/15 through 2/14/16, and that the Respondent is responsible for same. This time period covers the date of surgery through the date that Dr. Davis released the Petitioner to return to full duty work as of 2/15/16.

The Arbitrator notes that per Arbitrator's Exhibit 1, the Petitioner was requesting TTD benefits through 2/10/16. It is possible the Petitioner may have returned to work prior to 2/15/16. If so, the Petitioner is only entitled to benefits through the day before he may have returned to work prior to 2/15/16. He is not entitled to TTD benefits for any days he actually worked.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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

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

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors

used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. As such, this factor carries no weight in the determination of permanent partial disability.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a juvenile justice specialist at the time of the accident, and he has since returned to the same job after left shoulder surgery.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 38 years old at the time of the accident. Neither party provided any significant evidence that would indicate how this factor would impact the Petitioner's permanent partial disability. As such, this factor carries very minimal weight in the determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the evidence in this case does not reflect that the Petitioner's current and future income capacity have been impacted by the left shoulder injury. He has returned to his regular employment

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the Petitioner had a partial rotator cuff tear. He testified that he had a good result from his surgery but does continue to experience pain and soreness in his left shoulder. On 8/20/15, the Petitioner underwent a left shoulder arthroscopic rotator cuff repair of the subscapularis tendon, subacromial decompression, debridement of partial thickness bursal sided supraspinatus tendon tearing, residual biceps tendon stump, degenerative superior labral tearing and subacromial/subdeltoid adhesions. He also underwent open subpectoral biceps tenodesis. The postoperative diagnoses were: left shoulder partial thickness rotator cuff tear, left shoulder biceps tendinopathy, left shoulder subacromial outlet impingement, left shoulder degenerative labral fraying and left shoulder subacromial/subdeltoid adhesions. The Petitioner's last treatment report of 2/10/16 indicates he still complained of being a little sore and stiff, but felt he was continuing to improve. He returned to full duty as of 2/15/16. The therapy discharge report from 2/12/16 noted the Petitioner still had not reached all of his pre-therapy goals.

The Petitioner testified that when he returned to work, he still noticed some pain but indicated that it did not affect his ability to perform his work duties. He indicated that he still has soreness and pain in his left arm at almost all times. He notices the most pain when he performs activities such as mowing, weedeating, cleaning the swimming pool or washing a vehicle for too long. Petitioner testified that because of his injury he has stopped doing any of the hobbies that he did prior to the accident such as playing golf, basketball, volleyball and softball with his daughter. Overall, the disability is corroborated by the treating medical records.

The Petitioner did only have a partial cuff tear repaired, not a full tear, but he also underwent fairly extensive debridement of multiple structures, and did also undergo open biceps tenodesis. He also has some ongoing symptoms, which are consistent with the medical records. At the same time, he has returned to his regular job and there is no evidence he suffered any future earning capacity at this point. These factors carry the most weight in the determination of the Petitioner's permanency level.

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 11.5% loss of use of the person as a whole pursuant to §8(d)(2) of the Act, with regard to his left shoulder injury.

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

RAMONA STELLA,

Petitioner,

vs. NO: 09 WC 51271

TOWN OF CICERO,

Respondent.

18IWCC0377

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 medical expenses, causal connection and permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact and Conclusions of Law

Under the Arbitrator's Findings of Fact on page 13, the first full paragraph states as follows: "On June 8, 2011, at Respondent's request, Petitioner submitted to a §12 IME by Dr. Stephen Hartsock of AOMS. The report of this IME was not submitted into evidence and no evidence deposition was taken of Dr. Hartsock." The Commission finds Dr. Hartsock's opinion report was contained within Petitioner's exhibit number seven and entered into evidence without objection. The Commission, noting the Arbitrator's oversight of Dr. Hartsock's section 12 opinion report, strikes the words "The report of this IME was not submitted into evidence and" from the second sentence, revising it to the following: No evidence deposition was taken of Dr. Hartsock.

The last paragraph under section F: "Is Petitioner's current condition of ill-being causally related to the accident?" at the bottom of page 16 and the top of page 17, states Dr. Hartsock was retained by Respondent for a §12 evaluation of Petitioner and that Respondent did not submit a

report or his testimony based on his IME of Petitioner. The next sentence states the Arbitrator "cannot evaluate whether Dr. Hartsock's findings or opinions support or rebut Petitioner's or Respondent's theory of the case." As Dr. Hartsock's §12 opinion report is contained in Petitioner's exhibit number seven, the Commission finds the Arbitrator was not precluded from reviewing Dr. Hartsock's findings or opinions. The Commission further finds, however, this oversight is of *de minimis* consequence. The Commission, having reviewed Dr. Hartsock's report, is not persuaded by Dr. Hartsock's opinion that the Petitioner was at maximum medical improvement by June 8, 2011. The Commission further finds that the reinjury to Petitioner's ankle relied upon by Dr. Hartsock did not break the causal connection between her work-related injury and her condition of ill-being.

The Commission further finds on three occasions the Arbitrator misstates that Dr. Stamelos was retained by Respondent for a section 12 evaluation. Dr. Stamelos testified at his evidence deposition on direct examination that he was retained by Petitioner's attorney. (Px20, p. 12) The Petitioner testified that she went to an IME with Dr. Stamelos on October 12, 2015 and she went at Petitioner's attorney's direction. (11/19/15 T, p. 146)

Therefore, the Commission also modifies section "F" by striking the word "Respondent" from the second paragraph, second sentence on page 16 and substituting the words "Petitioner's Attorney" revising it to the following: As compelling are the opinions of orthopedic surgeon Dr. John Stamelos, who examined Petitioner and reviewed her medical records at the request of Petitioner's Attorney pursuant to §12 of the Act.

On page 17 under section J: "Were 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 Commission again strikes the word "Respondent's" and substitutes the word "Petitioner's" revising it to the following: The evidence within the records of Petitioner's treating physicians, as well as the opinions of Petitioner's retained IME examiner, Dr. Stamelos, clearly established the reasonableness and necessity of Petitioner's medical care.

On page 17, the last sentence under section L: "What is the nature and extent of the injury?" the Commission strikes the word "Respondent's" and substitutes the word "Petitioner's" revising it to the following: The evidence, particularly the opinions of Petitioner's IME physician, Dr. Stamelos, established that Petitioner has a permanent condition in her right wrist.

Based upon a review of the record, the Commission finds the opinions of Dr. Stamelos are more persuasive than those of Dr. Hartsock.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 6, 2017, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $611.53 per week for a period of 71.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 35% of the right hand.

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $611.53 per week for a period of 25.3 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 10% of the right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $611.53 per week for a period of 25.05 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 15% of the right foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $611.53 per week for a period of 2.7 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 10% of the right ring finger.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $79,412.26 for medical expenses pursuant to §8(a) and §8.2 of the Act as follows: Nicholas Ruvarac, D.C., $3,295.00; Rajeev Khanna, M.D./Advanced Occupational Medical Specialists, $18,215.00; Ronald Losiewicz/Multicare Medical Center, $6,846.00; John Sarantopoulos, O.D./Advanced Physical Medicine Associates, $9,830.00; Christine Sarantopoulos, D.P.M/Foot and Ankle Institute of Illinois, Ltd., $3,130.00 Srdjan Andre Ostric, M.D./Midwest Plastic and Reconstructive Surgery, $17,427.00; and Rogers Park/Lake Shore Surgery Center, $20,669.26.

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

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

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

DATED: JUN 13 2018
KWL/bsd
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Thomas J. Tyrrell

Michael J. Brennan

Dissent

I respectfully dissent from the decision of the majority. The Arbitrator was clearly under the impression that Respondent hired two different doctors to perform two §12 evaluations and the Arbitrator's Decision is entirely based upon that misconception. The Arbitrator relied upon Dr. Stamelos, Petitioner's retained expert, for his opinions, yet, referred to Dr. Stamelos as "Respondent's retained expert" or "Respondent's IME physician."

The majority dismisses the magnitude and impact of the oversight as "of *de minimis*" consequence, however, Dr. Hartsock saw Petitioner in 2011, two years after the accident, one year after she was released by her treating podiatrist and only months after she was released and discharged from care by her treating wrist surgeon. Petitioner did not see Dr. Stamelos until four years later, thus Dr. Hartsock was in a better position to judge Petitioner's condition in 2011.

The Petitioner's first choice of treatment was with chiropractor Ruvarac. Aside from the treatment at the Advanced Occupational Medical Clinic, her second-choice medical provider was chiropractor Losiewicz at The Multicare Health Center. She saw Losiewicz for the first time on December 8, 2009 for her right ankle, a little more than three months after the work-related accident and through March 1, 2011.

The chiropractor Losiewicz referred her to the osteopathic doctor, Dr. John Sarantopoulos (Dr. John) in the event she chose to continue therapy with him, for referrals. Petitioner consulted Dr. John for the first time on December 24, 2009 and through August 2011. (Px9) At the first visit Petitioner did not offer any complaints of right elbow or knee pain. (Px9) She was still seeing Dr. Ostric, her wrist surgeon. The chiropractor Losiewicz recommended a right ankle MRI after Dr. Ostric removed the hardware from her hand which was performed on February 1, 2010. On January 28, 2010 Petitioner then voiced complaints of right elbow pain in both the medial and lateral aspects. She had the right ankle MRI on February 18, 2010 and was referred to Dr. John's wife, a podiatrist, Dr. Christina Sarantopoulos. (Px9) A March 8, 2010 right elbow MRI confirmed no evidence of medial or lateral epicondylitis. The medial and lateral ulnar collateral ligaments were intact. There was nominal joint effusion so essentially all with normal limits. (Px9)

The Petitioner treated with Dr. Christina Sarantopoulos for her right ankle sprain for seven visits between February 2010 and July 2010, when she was released from care, approximately one year after the work-related accident. The Petitioner had minimal right ankle complaints during the period she treated with Dr. Christina Sarantopoulos, 0/10 "most of the time." (Px7, Px17) On July 26, 2010, the Petitioner returned to Dr. John Sarantopoulos for a prescription for wrist therapy with the chiropractor Losiewicz despite ongoing treatment with her wrist surgeon, Dr. Ostric. She reported she was still getting therapy and exercises to increase her dexterity at the physical therapy clinic. This was clearly overlapping and unnecessary treatment.

By September 28, 2010, Petitioner reported her right ankle felt much better. Petitioner participated in a Functional Capacity Evaluation (FCE) on October 26, 2010, a valid study that showed that she could perform the demands of her preinjury job. (Px7) At that time she had no right elbow complaints. *Id.*

Dr. Ostric, Petitioner's wrist surgeon opined Petitioner was at maximum medical improvement (MMI) on March 24, 2011. (Px13) Dr. Ostric addressed a letter to the Respondent opining she was at MMI, discharged from his active care and could return to work without any restrictions. He did not recommend any further physical therapy. He planned to do a follow-up visit six to eight weeks later at Petitioner's request. *Id.* Dr. Ostric then received a letter from the chiropractor, Ronald Losiewicz dated April 11, 2011. *Id.* Dr. Ostric wrote Dr. Khanna at Advanced Occupational Medicine Specialist on April 15, 2011 to address the issues referenced in the chiropractor's letter. *Id.* In his letter to Dr. Khanna, Dr. Ostric reiterated he did not recommend that Petitioner see any other physical or occupational therapist. *Id.* Dr. Ostric also opined Petitioner would not benefit further from chiropractic care nor did he believe it would be necessary to see a chiropractor at that time. *Id.*

The Petitioner was seen by Dr. Hartsock for a §12 evaluation shortly thereafter on June 8, 2011. (Px7) Petitioner reported a ten-year history since diagnosis of fibromyalgia to Dr. Hartsock. Dr. Hartsock opined the following: 1) Petitioner's right knee injury resolved relatively quickly and she was at MMI for her right knee injury; 2) Petitioner's right elbow injury was initially misdiagnosed by the first chiropractor, likely she had a right elbow contusion which elicited stiffness, her condition resolved and she was at MMI for her right elbow injury; 3) Petitioner's right ankle sprain/ligament tear had a more protracted course, but she had been discharged and at MMI for one year and her recent injury to the right ankle was non-work related (she reported she hurt herself on the curb by her home and it was non-work related. *see* p. 2); 4) Petitioner's right wrist was operated on and had a very good outcome and she was at MMI for her right wrist injury with current complaints expected; 5) Follow-up with Dr. Ostric when she will likely be discharged at next visit; 6) Petitioner may wear her right wrist splint at times with discomfort; 7) Petitioner should discontinue/wean off Vicodin and transition to anti-inflammatories or Tylenol as needed; 8) Petitioner should continue performing her home exercise program daily (for her wrist) as directed by therapy and Dr. Ostric; 9) Petitioner does not require any more physical therapy and has reached MMI for all of her injuries-her current therapy sounds more like massages and are things that have been taught to her with her home exercise program; 10) Petitioner should continue working full-duty. Dr. Hartsock opined Petitioner was fully recovered and at MMI for all her injuries. *Id.*

Therefore, all disputed medical bills after June 8, 2011 should be denied based on the following: 1) Dr. Christine Sarantopoulos, the podiatrist, had released Petitioner in July 2010; 2) Petitioner had a Functional Capacity Evaluation (FCE) on October 26, 2010, a valid study that included a musculoskeletal evaluation of her upper extremities (UE) with reported results on the functional pain scale (FPS) of "zero" or "one" on a scale of "one through ten" in all UE categories and showed that she could perform the demands of her preinjury job; and 3) Dr. Ostric, her wrist surgeon, released Petitioner at MMI on March 24, 2011.

Next, the permanent partial disability (PPD) award is excessive. All medical providers agreed the Petitioner had a classic "ankle sprain" and the PPD award should not exceed 10% loss of use of a right foot. Within three months after the accident, when Petitioner first saw chiropractor Losiewicz on December 8, 2009, he noted she had a very minute amount of swelling at the inferior lateral malleolus and full range of motion in the right ankle. She had full strength with plantar flexion as well as dorsiflexion, no laxity with anterior and posterior drawer and some pain. Her findings both

before and after MRI were consistent with a chronic ankle sprain.

Furthermore, Petitioner's first chiropractor misdiagnosed her right elbow condition. She had a right elbow contusion and aggravation of a pre-existing condition which was completely resolved by the time she saw Dr. Hartsock, and there is evidence the elbow condition was resolved by the time she had her FCE, if not before. The right elbow complaints that Petitioner had in 2012 are unrelated to the 2009 subject work-related accident. Conceding her complaints of flexor and extensor muscle pain in her forearm, the PPD award for the right arm should not exceed 5% loss of use of a right arm.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STELLA, RAMONA
Employee/Petitioner

Case# **09WC051271**

TOWN OF CICERO
Employer/Respondent

18IWCC0377

On 1/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.63% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2545 SHELDON I MINKOW & ASSOCIATES
PO BOX 1054
NORTHBROOK, IL 60065

4217 DEL GALDO LAW GROUP LLP
GEORGE S SPATARO
1441 S HARLEM AVE
BERWYN, IL 60402

STATE OF ILLINOIS)
SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

Ramona Stella
Employee/Petitioner
v.
Town of Cicero
Employer/Respondent

Case # **09 WC 51271**

18IWCC0377

An *Application for Adjustment 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 **11/19/2015, 11/20/2015** and **4/28/2016.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/26/2009**, 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 **$53,000.00**; the average weekly wage was **$1019.22**.

On the date of accident, Petitioner was **46** 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**.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$611.53**/week for **71.75** weeks, because the injuries sustained caused the **35%** loss of the **right hand**, as provided in §8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$611.53**/week for **25.3** weeks, because the injuries sustained caused the **10%** loss of the **right arm**, as provided in §8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$611.53**/week for **25.05** weeks, because the injuries sustained caused the **15%** loss of the **right foot**, as provided in §8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $611.53/week for **2.7** weeks, because the injuries sustained caused the **10%** loss of the **right ring finger**, as provided in §8(e) of the Act.

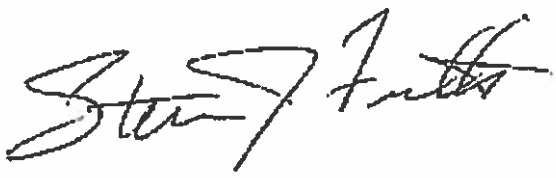
Respondent shall pay reasonable and necessary medical services of **$79,412.26**, as provided in §8(a) of the Act and according to the fee schedule provided by §8.2 of the Act as follows: Nicholas Ruvarac, D.C., **$3,295.00**; Rajeev Khanna, M.D./Advanced Occupational Medical Specialists, **$18,215.00**; Ronald Losiewicz/Multicare Medical Center, **$6,846.00**; John Sarantopoulos, O.D./Advanced Physical Medicine Associates, **$9,830.00**; Christine Sarantopoulos, D.P.M./Foot and

Ankle Institute of Illinois, Ltd., **$3,130.00**; Srdjan Andre Ostric, M.D./Midwest Plastic and Reconstructive Surgery, **$17,427.00**; and Rogers Park/Lake Shore Surgery Center, **$20,669.26.**

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

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

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



Signature of Arbitrator

January 6, 2017
Date

JAN 6 – 2017

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***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 was the only witness who testified at the trial.

FINDINGS OF FACT

Petitioner Ramona Steele is a 52-year-old right-hand dominant female employed by Respondent Town of Cicero as a clerk in the Compliance Section of the Cicero Building Department. In her current position, Petitioner works 4 days per week at 10 hours per day for a total of 40 hours per week. In her current capacity as a clerk, Petitioner performs data entry 75% of each day where she uses both hands to type information into a computer. The remainder of her workday is spent notarizing documents and working with attorneys and realtors concerning Building Department business.

Petitioner testified that she began employment with Respondent on 1995, as a customer service representative and cashier with the Cicero Water Department. She performed data entry and took in customer complaints and payments. In January 2005, her position changed to supervisor of the Cicero Annex Building, which was a satellite location of Respondent's main Town Hall. In her supervisory capacity, Petitioner supervised 2 clerks and performed duties similar to her prior role in the Water Department except she did not perform any cashier functions. Petitioner continued her role at the Annex Building until January 2010, when the Annex Building was permanently closed. Petitioner was then transferred back to the main Cicero Town Hall where she resumed the same data entry and customer service duties as she performed for the Water Department. In August 2014, Petitioner's position changed and she was assigned her current duties with the Building Department.

Petitioner testified that on August 26, 2009, she was on the job in her capacity as supervisor of the Annex Building. She began work at her normal starting time of 8:00

a.m. When Petitioner arrived at work August 26 she found that her office computer was not working. Petitioner testified that as you face into the entrance of her office, there is a copy machine located to the immediate right of the entry door. Petitioner contacted the Cicero IT department and learned that there had been a power outage. She was advised to unplug all electrical items including her computer.

Petitioner followed the IT instructions and unplugged all items including her computer and laid out least 6 cords and plugs on the floor by her desk. After laying out the cords and plugs, Petitioner left her office to take care of a work-related problem in the front area outside of her office and then returned to her office to further address the computer issue and contact the IT department. Petitioner testified that as she approached her office desk she stepped on one of the cords with her right foot, causing her right ankle to twist and roll to the right and causing her to fall to the floor. As she fell, Petitioner's right elbow, right wrist, and right arm struck the copy machine located in her office. Petitioner landed on her right side.

Petitioner had immediate pain to her right ankle, right knee, right elbow, and right wrist. As she tried to get up Petitioner had difficulty putting pressure on her right foot. Additionally, she noticed that her right knee and right hand were bloody and scraped. Immediately following the accident, Petitioner's two staff persons, Diane Soto and Bertha Rodriguez, apparently hearing the sound of Petitioner's fall, rushed to Petitioner's. Petitioner testified that she did not immediately notify her supervisor of the accident because she did not initially think her injuries were serious. She felt that if she stayed on her feet for a few hours, the pain would eventually resolve.

Petitioner continued to work for the rest of her shift that day. During the remainder of the workday, her pain and symptoms did not resolve. Petitioner testified that she only lived 3 miles from work, so she felt capable of driving home after her shift ended that day. At home she noticed that her right foot and ankle were so swollen that she could not get her shoe back on. She also noticed that her right elbow was scraped and had been bleeding. At home Petitioner's right elbow pain was 5/10; her right ankle pain was 8/10. Petitioner testified that she continued to have difficulty walking, climbing stairs and putting pressure on her right foot; while her right wrist pain seem to be increasing.

Petitioner did not return to work the following day, August 27, because her pain had not improved. She phoned Cicero HR director, Derek Dominick, and left a voice message reporting her accident and that she would not be coming to work that day. That same day, Petitioner sought medical attention with chiropractor Dr. Nicholas Ruvarac. On her first visit, Petitioner gave Dr. Ruvarac with a history of the August 26 work accident and her complaints. Dr. Ruvarac took x-rays of Petitioner's right wrist,

right arm, and right ankle, which revealed a right wrist scapholunate tear (PX #3). Dr. Ruvarac reviewed the x-rays with Petitioner. She saw on the separated bones in her right wrist. Petitioner also testified that she saw her right arm x-rays, which had a shadow on her upper right arm. After talking to Dr. Ruvarac she believed represented a fracture to the right elbow area. Dr. Ruvarac provided a sling for her right arm and a brace for her right knee and right ankle and also an off-work slip.

Petitioner testified that on August 27, following her visit to Dr. Ruvarac, she faxed a memorandum (PX #1) to Derek Dominick summarizing the facts of the August 26 work accident. She attached a type-written note from Dr. Ruvarac dated August 27 (PX #2) detailing his exam and findings; and which, in particular, noted that Petitioner suffered a fall at work August 26, 2009 and that Petitioner presented with right ankle, right knee, right wrist, and right elbow swelling and pain. Dr. Ruvarac further detailed that x-rays revealed a possible tear of the fibulotalor ligaments of the right ankle, a possible fracture right elbow, and a possible tearing of the scapholunate ligament of the right wrist.

Petitioner further testified that a little later she began to experience pain and symptoms to her low back in addition to her other injuries.

Petitioner treated with Dr. Ruvarac from August 27 through October 27, 2009 (PX #3). During this period of treatment, Petitioner continued to have low back stiffness, right ankle pain, right knee pain, right wrist pain, and right elbow pain. Petitioner testified that within the first 2 weeks of care, Dr. Ruvarac treated her with a long arm cast which extended from her right elbow to her right wrist. After 2 weeks, the initial cast was removed and replaced with a more comfortably fitted long arm cast. In all, Petitioner wore a long arm cast for approximately 5 weeks. During the course of her care, Petitioner saw Dr. Ruvarac 3 times per week. She was examined each visit and received therapy for her low back, right knee, right ankle, right elbow, and wrist conditions (PX #3).

On Petitioner's last visit to Dr. Ruvarac on October 27, 2009, Petitioner reported much less pain in her right ankle, right knee, and right elbow were less severe. The low back symptoms were essentially resolved (PX #3). Petitioner testified that even though her right ankle condition had improved somewhat by her last visit to Dr. Ruvarac, the right side of her right ankle was still purple and discolored and she still had increased levels of pain with right ankle activity. Petitioner testified that she was still having right wrist pain on her last visit with Dr. Ruvarac. Nonetheless, Dr. Ruvarac release Petitioner from active care.

Petitioner testified, that prior to her release by Dr. Ruvarac, she was instructed by HR director, Derek Dominick, to see Rajeev Khanna, M.D., at Advanced Occupational Medicine Specialists (AOMS). This was the clinic Cicero employees were required to seek treatment for workers' compensation claims and work-related accidents. The records of AOMS contain the report of Dr. Khanna dated September 29, 2009, noting that he saw Petitioner on that date for an IME requested by Respondent (PX #5).

Petitioner testified that Dr. Khanna assumed primary care as her treating physician. Dr. Khanna treated Petitioner from September 29, 2009 through October 18, 2010 (PX #5). Petitioner testified that her first visit to AOMS on 9/29/09, Dr. Khanna never explained to her that he was conducting an IME and he never advised that she was not required to treat with him for her injuries. Petitioner further testified that she did not have an attorney at the time and that it was her impression that she was required to treat with Dr. Khanna and AOMS since she was directed to see him by Respondent as he was the Town's doctor.

When Petitioner first saw Dr. Khanna, she was still wearing the long arm cast fitted by Dr. Ruvarac. Dr. Khanna noted the history of the August 26 accident. Dr. Khanna also noted that Petitioner's right knee pain had resolved but that she continued to complain of 6/10 right ankle pain, 5/10 right wrist pain, and 5-6/10 right elbow pain (PX #5). Dr. Khanna took x-rays of Petitioner's right elbow and opined that the x-rays did not show any evidence of a recent fracture. Dr. Khanna continued physical therapy orders for Petitioner's right ankle and returned her to work at light-duty with no use of her right arm.

On October 6, 2009, Dr. Khanna ordered an MRI of Petitioner's right wrist, which was also performed that same day at Community Imaging (PX #5). The MRI showed a widening of the scapholunate interval which measured 3.5 mm. On October13, Dr. Khanna read the MRI as a right wrist disruption and referred Petitioner to hand surgeon, Srdjan Andre Ostric, M.D. of Midwest Plastic and Reconstructive Surgery.

Petitioner saw Dr. Ostric pursuant to Dr. Khanna's referral October 15, 2009 (PX #13). She treated with Dr. Ostric for her right wrist from October 15, 2009 through March 24, 2011. Petitioner testified that she always saw Dr. Ostric at AOMS. On October 15 Dr. Ostric, based on his exam and review of the October 6 MRI, determined that Petitioner suffered a right scapholunate tear that was approximately 2 months old. Additionally, Dr. Ostric recommended right wrist ligament reconstruction surgery. Dr. Ostric opined that Petitioner should expect that after surgery and rehabilitation she will have residual wrist symptoms.

Dr. Ostric performed surgical reconstructive scapholunate ligament repair with placement of hardware to Petitioner's right wrist at Rogers Park/Lake Shore Surgery Center on November 13, 2009 (PX #18). Dr. Ostric's post-operative diagnosis was a right scapholunate disassociation with partial tearing. The operative report further noted scapholunate ligament stabilization through percutaneous pinning with thermocoagulation and a dorsal intercarpal capsulodesis using the dorsal intercarpal ligament (PX #18). Petitioner testified that following surgery, she was placed in a cast like long arm brace extending from her right elbow to her right wrist.

Petitioner continued post-operative visits with Dr. Ostric through December 10, 2009. On December 10, Dr. Ostric removed a fixation pin in his office due to Petitioner's increasing discomfort (PX #13). Following the pin removal, Petitioner continued her post-operative visits with Dr. Ostric during which she noticed increasing right wrist pain to her right caused by the fixation hardware from her November 13 surgery (PX #13).

On February 1, 2010, Dr. Ostric performed a further surgical procedure to remove fixation hardware from Petitioner's right wrist (PX #18). The surgery was also performed at Rogers Park/Lake Shore Surgery Center as an outpatient procedure. Petitioner testified that not all of the hardware was removed during the February 1 surgery and to her knowledge a screw remains permanently in her right wrist. Following the hardware removal surgery, Petitioner continued with her monthly post-operative visits with Dr. Ostric.

On March 4, 2010 Dr. Ostric diagnosed Petitioner was diagnosed with a right ring trigger finger which was treated with injections (PX #13). Concurrent with Petitioner's post-operative visits to Dr. Ostric, she was receiving physical therapy for her right wrist from AOMS from February 16 through October 18, 2010, at 3 times per week for a total of 53 visits (PX #5).

On October 26, 2010, a functional capacity exam (FCE) was performed at AOMS pursuant to the orders of Dr. Ostric (PX #17). The FCE determined that Petitioner was capable of returning to work at her Light demand pre-injury job. However, the November 4, 2010 progress note of Dr. Ostric noted that Petitioner will continue with symptoms and that she will have some persistent wrist pain as a result of her injury (PX #13). Petitioner's last visit with Dr. Ostric was March 24, 2011, at which time Dr. Ostric determined that Petitioner was at MMI with her right wrist and that she could return to her pre-injury job with Respondent without restrictions (PX #13).

Petitioner continued to treat with Dr. Khanna at AOMS for her right ankle and right elbow conditions from October 15 through November 5, 2009 (PX #5). The treatment consisted of medication management and physical therapy for the right ankle and right elbow (PX #5 & PX #6). Petitioner testified that on her last visit to Dr. Khanna on November 5, 2009 her right ankle was still 8/10 and that she was still having difficulty walking and putting pressure on her right foot and ankle.

Petitioner testified that this point of care, she was not satisfied with the treatment provided by Dr. Khanna as to her right ankle or right elbow. Petitioner felt that Dr. Khanna was only providing her with pain medication to mask her symptoms as opposed to treating and resolving her condition. She terminated further care with Dr. Khanna and began treating with chiropractor Ronald Losiewicz, D.C. at Multi Care Medical Center. It was more convenient for Petitioner to see Dr. Losiewicz because his office was only 1 ½ miles from her home, whereas Dr. Khanna was located approximately 17 miles away.

Petitioner treated with Dr. Losiewicz from December 8, 2009 through March 1, 2011 (PX #7). On her first visit, Petitioner gave a history of her work accident and complained of 5/10 right ankle pain, with weakness and pain at the inferior and posterior portions of the lateral malleolus. Dr. Losiewicz treated the right ankle with physical therapy 3 times per week through December 23, 2009, pursuant to a previous 2 week therapy script by Dr. Khanna. Dr. Losiewicz referred Petitioner to osteopathic physician, John Sarantopoulos, O.D. at Advanced Physical Medicine Associates (APMA) for pain management and oversight of her medical care (PX #7).

Petitioner first saw Dr. Sarantopoulos was on December 24, 2009 (PX #9). Petitioner gave a history of her August 26, 2009 work accident and her continuing complaints of pain in her right wrist, pain and numbness to her right hand, and continuing right ankle pain. Dr. Sarantopoulos continued Petitioner's scripts for ankle therapy with Dr. Losiewicz, who provided physical therapy for the right ankle 3 times a through February 2, 2010 (PX #7).

Petitioner's right ankle condition did not respond to therapy. Dr. Sarantopoulos ordered an MRI, which was performed on February 12, 2010 at Western Open MRI (PX #9 & PX #15). The MRI revealed a chronic tearing of the inferior talofibular ligament of the right ankle. On February 18, 2010, pursuant to the MRI findings, Dr. John Sarantopoulos referred Petitioner for further right ankle care to his wife, podiatric physician Christine Sarantopoulos, D.P.M., at Foot and Ankle Institute of Illinois, Ltd. (PX #9). Petitioner testified that at the time of referral, Dr. J Sarantopoulos advised her

of his relationship to Dr. C Sarantopoulos, and that she could see a different physician if she so desired.

Petitioner treated with Dr. C Sarantopoulos for her right ankle from February 19 through July 7, 2010. On Petitioner's first visit, she provided a history of her work accident and her complaints of right ankle pain with pain varying from 3-9/10 maximum, depending on activities (PX #11). Dr. C Sarantopoulos confirmed the MRI findings and diagnosed Petitioner's right ankle condition as a chronic talofibular ligament tear, peroneal tendinitis, and STJ (subtalar joint) synovitis due to the work injury of August 26, 2009. Petitioner's right foot and ankle were immobilized with an air cast and later a Cam boot. Dr. C Sarantopoulos injected Petitioner's right ankle with lidocaine and prednisone right ankle May 17, 2010 (PX #11). Petitioner testified that she wore the Cam boot all day for several months.

Petitioner continued to receive physical therapy from Dr. Losiewicz 2-3 times per week pursuant to orders from Dr. C Sarantopoulos from February 17 through July 22, 2010 (PX #7 & PX #7). Petitioner testified that as of her last visit to Dr. C Sarantopoulos, July 7, 2010, her right ankle pain had improved; however, the ankle was still weak and would frequently roll when she walked. She had to utilize lace up shoes for support. Petitioner did not receive further medical care for her right ankle from Dr. C Sarantopoulos after July 7 and her last physical therapy session for her right ankle by Dr. Losiewicz was on July 22, 2010.

Petitioner continued to treat with Dr. J Sarantopoulos and APMS from December 24, 2009 through August 18, 2011 for pain management and symptoms related to her right elbow and post-surgical right wrist/hand conditions (PX #9). On March 4, 2010 Dr. J Sarantopoulos referred Petitioner for a right elbow MRI, due to complaints of persistent complaints of elbow pain. Dr. J Sarantopoulos reviewed the MRI March 8, 2010 and diagnosed right lateral epicondylitis. He referred Petitioner for physical therapy, which was performed by Dr. Losiewicz in the form of strengthening exercises and ultrasound (PX #7). During the period that Petitioner received physical therapy from Dr. Losiewicz, she continued to receive pain management from Dr. J Sarantopoulos for her right elbow and right wrist and hand. The pain management included scripts for meloxicam for pain and inflammation, hydrocodone with acetaminophen for pain, and gabapentin for pain and numbness (PX #9).

Following Petitioner's release from physical therapy with Dr. Losiewicz on March 1, 2011 and her release from Dr. Ostric on March 24, 2011, Dr. J Sarantopoulos continued to provide medication management for Petitioner's post-surgical right wrist

and right elbow epicondylitis conditions (PX #9). Petitioner's right epicondylitis improved by October 14, 2010.

Petitioner's right wrist and hand pain remained unresolved (PX #9). Petitioner's last visit with Dr. J Sarantopoulos was August 18, 2011, at which time she continued to complain of chronic right wrist and hand 4/10 pain. The August 18 progress note documented Petitioner's complaints that without the pain medication, her pain was closer to 8/10. Dr. J Sarantopoulos ordered continuation with the medication as prescribed.

Petitioner was initially ordered off work by Dr. Ruvarac, for the period August 27 through October 4, 2009. Pursuant to Dr. Ruvarac's orders Petitioner returned to work for ½ days on restricted duty from October 4 through October 27, 2009. After October 27, Petitioner returned to work full time with right-hand use restrictions (PX #3). When Petitioner began treating with Dr. Khanna, he continued the return to work orders of Dr. Ruvarac and had Petitioner return to work full time with right-hand restrictions from October 29 through November 13, 2009 (PX #5). Following Petitioner's first wrist surgery, Dr. Ostric ordered her off work from November 13 through December 17, 2009 (PX #13). Pursuant to Dr. Ostric's orders, Petitioner to returned to work for 4 hours per day at light-duty from December 17, 2009 through February 4, 2010 (PX 13). In accord with Dr. Ostric's orders, Petitioner returned to work with light-duty restrictions at 6 hours per day from February 4 through November 4, 2010 (PX #13). Petitioner gradually reached her pre-injury full time work hours with Respondent by March 24, 2011 (PX 13).

Petitioner's right knee and low back problems resolved by the time she saw Dr. Khanna. Her right elbow epicondylitis condition resolved by her last visit to Dr. J Sarantopoulos. However, Petitioner testified that she has right wrist and hand and right ring finger pain to the present time. Her right wrist condition has been further complicated by the development of right arm tendinitis which began evolving after her surgery by Dr. Ostric. Petitioner testified that while working for Respondent during the period of 1998 through 2000 she developed right arm tendinitis as a result of frequent cashier duties. However, that tendinitis condition, which she developed in 1998, resolved by 2002. Since that time she did not have any further tendinitis symptoms to her right arm until after her August 26, 2009 accident. Petitioner testified that the right arm tendinitis which she now experiences through the present date, is not the same type of tendinitis symptoms she experienced 1998 through 2000.

Petitioner testified that as a result of the post-surgical symptoms to her right wrist/hand and right ring finger and her right forearm tendonitis, she cannot do many

of the things she used to do prior to her work accident and suffers right wrist and hand and right forearm pain, weakness and cramping with frequent and repetitive use of her right hand and forearm especially when she attempts activities which require repetitive hand use and manipulation, lifting and carrying items and if the right hand and forearm are exposed to cold weather. Daily activities of life which result in cramping and pain to her right wrist, hand and forearm includes use of a blow dryer for her hair; use of curling iron or brush; cooking stirring or kneading with her right hand; opening jars bottles of water; carrying groceries, household activities such as scrubbing floors, raking leaves for gardening; or driving her motor vehicle especially during long distances during which the right wrist pain is so bad that she cannot use her right hand to steer and is required to rest her right hand on the bottom of the steering wheel while driving.

Petitioner testified that her right wrist and forearm pain becomes elevated when performing duties at work that require repetitive right wrist/hand and right arm movement such as writing and data entry. She cannot write for extended periods of time at work and has to stop 3-4 times before completing a page. She also has symptoms of cramping and pain to her right wrist, hand, and forearm when performing data entry on a regular basis. Petitioner noted that the tendinitis condition to her right forearm bothers her with increased activity and that at the end of a normal workday, her right forearm feels painful and swollen. When the workday becomes hectic, then Petitioner's pain score for her right forearm can elevate as high as 8/10. She testified that prior to the August 26, 2009 accident she could perform data entry 8-10 hours per day without any symptoms. However, since the accident, the tendinitis condition to her right forearm is constant and bothers her with increased activity and changes in weather.

On April 16, 2012 Petitioner began experiencing increased right wrist and right forearm pain while performing data entry for Respondent. She was referred by HR to see Dr. Khanna, who treated her conservatively on April 26 and May 3, 2012 with instructions for icing the injured area and to do stretching exercises (PX #5). Dr. Khanna notes document Petitioner's complaints of 9/10 right forearm pain and 4/10 wrist pain. Petitioner testified that the problems experienced at work on April 16 is an example of the symptoms she regularly experiences to her right wrist/hand and right forearm when at work performing her work duties which includes data entry and other repetitive tasks with her right wrist/hand and right arm.

Petitioner testified that she does not presently have right ankle pain except with changes in weather, at which time she experiences an "achy" type of pain in the right ankle. She further testified that her right ankle demonstrates significant weakness and rolls frequently when she walks. Since her accident, she has to be careful of the type of

shoes she wears because the ankle is not stable anymore and is kind of "shaky" and she cannot wear high heels. Petitioner testified that except for the period of 1998 through 2000 (when she experienced some symptoms of tendinitis which resolved by year 2000), she never sustained any injuries or experienced any other symptoms of pain or restrictions concerning her low back, right knee, right wrist, right hand, right forearm, right ring finger or right ankle.

On June 8, 2011, at Respondent's request, Petitioner submitted to a §12 IME by Dr. Stephen Hartsock of AOMS. The report of this IME was not submitted into evidence and no evidence deposition was taken of Dr. Hartsock.

On October 12, 2015 Petitioner submitted to another §12 IME exam, this by orthopedic surgeon, John Stamelos, M.D. Dr. Stamelos' findings and opinions are contained in his written report dated October 12, 2015 (PX #22). He testified to his findings and opinions in his evidence deposition on February 23, 2016 (PX #20). Dr. Stamelos has significant experience in the treatment of traumatic injuries to hands, fingers, wrist, elbows, arms, knees, ankles and the back; and significant experience in the diagnosis, treatment and participation in the surgical care of scapholunate tears of the wrist (PX #20). Dr. Stamelos' IME included a hands-on physical examination of Petitioner and a review of the medical records of Petitioner's treating medical providers Dr. Ruvarac, Dr. Khanna/AOMS, Dr. Ostric, Dr. Losiewicz/Multicare Medical Center, Dr. John Sarantopoulos/APMS, Dr. Christine Sarantopoulos/Foot and Ankle Clinic of Illinois, Ltd., Community MRI images of October 6, 2009, and Dr. Hartsock's June 8, 2011 IME report.

Dr. Stamelos testified that at the IME, Petitioner gave a complete history of her August 26, 2009 work accident, her medical history both prior and subsequent to the accident, and a history of her work duties (PX #20). Dr. Stamelos testified that the history as provided by Petitioner as to the mechanics of the work accident and her medical condition was consistent with the medical records which he reviewed. Petitioner reported current complaints of continued pain and discomfort with cramping and limited mobility of her right upper extremity and regular bouts of tendinitis in her right forearm. Petitioner complained of specific restrictions any time she used her right wrist and hand including activity such as driving, using a curling iron or trying to push off from a chair armrest. She further complained that after any sustained or long-term writing beyond 5 minutes, she has to stop as her right wrist/hand cramps and become sore. Petitioner has regular pain in her right palm and distal forearm that causes tightness and loss of grip strength. Dr. Stamelos felt that Petitioner's complaints during the exam appeared to be genuine (PX #20).

During the IME, Dr. Stamelos performed measurements of Petitioner's right wrist/hand strength and range of motion and found 35° of dorsiflexion on the right compared to 75° on the left; 30° volar flexion (palmar flexion) on the right compared to 60° on the left; 15° radial flexion (going to thumb side) on the right compared to 65° on the left. Dr. Stamelos determined from his measurements, that Petitioner had significant restrictions to strength and movement of her right wrist which will be a permanent limiting factor to certain hand movements requiring twisting and certain hand positions (PX #20).

Dr. Stamelos commented on the October 6, 2009 right wrist MRI images (DepX #5). These images were prior to Petitioner's surgeries by Dr. Ostric. Based on his review of the medical records, review of the October 6 MRI, and his examination of Petitioner, Dr. Stamelos opined that as a direct result of her August 26, 2009 work accident and fall Petitioner suffered a scapholunate tear and disassociation to her right wrist, a deep bone bruise or occult fracture of her right elbow, and a chronic tear of the anterior talofibular ligament of the right ankle (PX #20). Dr. Stamelos further opined that Petitioner's right ring finger and right forearm tendinitis were the expected sequelae of the scapholunate tear and reconstruction surgery performed to the right wrist by Dr. Ostric. He also opined that the direct cause of the injuries and conditions and sequelae suffered by Petitioner was the accident and fall of August 26, 2009 (PX #20). Dr. Stamelos further noted that his review of the medical records of Petitioner's medical providers, the IME report of Dr. Hartsock, and the history of the accident provided at the IME by Petitioner indicated that Petitioner sustained a rug burn to the palmar aspect of her right wrist which indicates that the impact of the fall jammed Petitioner's right wrist with sufficient force and is the exact mechanism which will cause a tear of the scapholunate ligament as sustained by Petitioner (PX #20).

Dr. Stamelos testified that the scaphoid and lunate bones are the key bones in the wrist that articulate and form a joint with the radius in the forearm and allows for movement and strength in the wrist (PX #20). He testified that his review of the October 6, 2009 MRI showed a separation between the scaphoid and lunate bones of 3.5 mm. Normally, the space should be at 2 mm. Dr. Stamelos opined that the severity of the scapholunate tear sustained by Petitioner necessitated the November 8, 2009 capsulrraphy and capsulodesis surgery by Dr. Ostric. Dr. Stamelos noted that Dr. Ostric affixed anchors and hardware to stabilize Petitioner's scapholunate ligament and right wrist (PX #20). He further testified that subsequent to the surgery, as a result of post-surgical discomfort and pain it was necessary for Dr. Ostric to perform a pin removal procedure and a second open surgical procedure later in 2010 to remove most of the hardware placed in Petitioner's wrist during the first surgery. Anchors were left in the right wrist which will remain throughout Petitioner's life.

Dr. Stamelos further opined that Petitioner sustained permanent disability and impairment as a result of the August 26, 2009 work accident to her right hand, wrist and forearm as well as to her right ankle (PX #20). Dr. Stamelos testified that the surgeries performed by Dr. Ostric caused a denervation to Petitioner's right hand and wrist which will result in areas of numbness and tingling. This was documented in Dr. Ostric's post-surgical progress notes of January 27, 2011 and March 4, 2011. Dr. Stamelos further testified that 25%-30% loss of strength and 50% loss of range of motion which Petitioner suffered to her right wrist (as evidenced by his examination) is an expected result of the type of reconstruction surgery performed by Dr. Ostric (PX #20). The complaints and symptoms observed in Petitioner at the IME are typical of the residual effects of a scapholunate tear and reconstruction surgery and are supported by the available medical studies and literature. Additionally, Dr. Stamelos testified that the recurring tendinitis to Petitioner's right forearm is due to inflamed and irritated tendons which are forced to work overtime due to the loss of range of motion and strength suffered to the right wrist. Petitioner will always have recurring tendinitis as a result of the injury to the wrist (PX #20). Dr. Stamelos opined that no further surgery would be required for Petitioner's right wrist. However, Petitioner may require tendon injections or anti-inflammatories like cortisone for the recurring tendinitis.

Dr. Stamelos opined that the chronic talofibular tear to the right ankle suffered by Petitioner in the August 26, 2009 work accident is a classic sprain type injury (PX #20). He testified that the initial right ankle injury was acute but developed into a chronic condition. Dr. Stamelos testified that ligament injuries can have a permanency aspect because they heal with scar tissue. However, no further care will be required for the right ankle condition. According to Dr. Stamelos, Petitioner's permanency as to the right ankle will be limitations as to wearing high heels and involvement in prolonged running activities. Additionally, Petitioner may notice some swelling around the anterolateral aspect of the right ankle if she is on her feet all day long.

Dr. Stamelos finally opined that the medical care provided to Petitioner by Dr. Ruvarac, Dr. Khanna/AOMS, Dr. Ostric, Dr. Losiewicz/Multicare Medical Center, Dr. John Sarantopoulos/APMS, Dr. Christine Sarantopoulos/Foot and Ankle Institute of Illinois, Ltd. and Rogers Park/Lake Shore Surgery Center was reasonable and necessary to treat the injuries caused by the work accident of August 26, 2009 (PX # 20).

Petitioner submitted medical bills and charges incurred by Petitioner to treat the conditions she sustained as a result of the August 26, 2009 work accident: Nicholas Ruvarac, D.C. - $3,295.00 (PX #4); Rajeev Khanna, M.D./AOMS - $18,215.00) (PX #6); Ronald Losiewicz/Multicare Medical Center - $6,846.00 (PX #8); John Sarantopoulos, D.O./ APMS - $9,830.00 (PX #10); Christine Sarantopoulos, D.P.M/Foot and Ankle Institute of Illinois, Ltd. - $3,130.00 (PX #12); Srdjan Andre Ostric, M.D. /Midwest

Plastic and Reconstructive Surgery - $17,427.00 (PX #14); Rogers Park/Lake Shore Surgery Center - $20,669.26 (PX #19).

CONCLUSIONS OF LAW

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

This issue was not genuinely disputed. Petitioner testified credibly that she was engaged in activities incidental to her employment by Respondent. She had reported to work after a vacation to find that her computer and other electronics had been affected by a power outage in her absence. She was endeavoring, with the assistance of Respondent's IT personnel, to get her computer operating properly. She was directed to unplug the electronics. As she was attempting to unplug equipment she tripped and fell and was injured.

The Arbitrator finds that based on all the evidence that petitioner proved that she was injured in an accident 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 accident?

Petitioner proved that the conditions of ill-being in her right hand and wrist, her right foot and ankle, her right ring finger, and her right elbow ere causally related to her work accident on August 26, 2009.

Petitioner's course of medical care and treatment, particularly by Drs. Ruvarac, Khanna, Ostric, John Sarantopoulos, and Christine Sarantopoulos clearly established that the injuries and conditions diagnosed and treated were causally related to the work accident. Petitioner was a credible, accurate, and consistent historian when she was treated by these physicians. As compelling are the opinions of orthopedic surgeon Dr. John Stamelos, who examined Petitioner and reviewed her medical records at the request of Respondent pursuant to §12 of the Act. Dr. Stamelos confirmed Petitioner's diagnoses and their cause. He also confirmed the reasonableness and necessity of the medical care provided to cure or relieve the effects of Petitioner's accidental injuries.

Respondent retained Dr. Stephen Harstock for a §12 IME of Petitioner. Respondent did not submit a report from Dr. Harstock or his testimony based on his

IME of Petitioner. The Arbitrator cannot evaluate whether Dr. Harstock's findings or opinions support or rebut Petitioner's or Respondent's theory of the case.

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

Based on findings set forth above the Arbitrator finds that the medical care and treatement provided by physicians and facilities set forth in the evidence was reasonable and necessary to cure or relieve the effects of Petitioner's injuries sustained in her work accident on August 26, 2009. The evidence within the records of Petitioner's treating physicians, as well as the opinions of Respondent's retained IME examiner, Dr. Stamelos, clearly established the reasonableness and necessity of Petitioner's medical care.

Petitioner submitted medical bills and charges incurred by Petitioner to treat the conditions she sustained as a result of the August 26, 2009 work accident: Nicholas Ruvarac, D.C. - $3,295.00 (PX #4); Rajeev Khanna, M.D./AOMS - $18,215.00) (PX #6); Ronald Losiewicz/Multicare Medical Center - $6,846.00 (PX #8); John Sarantopoulos, D.O./ APMS - $9,830.00 (PX #10); Christine Sarantopoulos, D.P.M/Foot and Ankle Institute of Illinois, Ltd. - $3,130.00 (PX #12); Srdjan Andre Ostric, M.D. /Midwest Plastic and Reconstructive Surgery - $17,427.00 (PX #14); Rogers Park/Lake Shore Surgery Center - $20,669.26 (PX #19). Respondent shall pay any outstanding balance owed on these medical charges in accord with §8(a) of the Act, adjusted in accord with the fee scheduled provided by §8.2 of the Act.

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

The evidence clearly established that Petitioner sustained injuries to her right hand and wrist, her right ring finger, her right elbow, and her right foot and ankle. Petitioner also had some low back pain and a right knee sprain. Petitioner was diagnosed with a scapholunate tear in her right wrist. She was diagnosed with epicondylitis in her right elbow. She was also diagnosed with a talofibular tear in the right ankle. She was diagnosed with a trigger finger of the right ring finger. Petitioner's right elbow epicondylitis, right knee sprain, and low back pain have essentially resolved. Petitioner does have some slight recurrent complaints with her right elbow.

A different picture is presented Petitioner's right wrist and right ankle injuries. Several surgical procedures were required for treatment of Petitioner's right wrist. The evidence, particularly the opinions of Respondent's IME physician, Dr. Stamelos,

established that Petitioner has a permanent condition in her right wrist. There is weakness, loss of motion and strength, and continuing pain in the right wrist. Dr. Stamelos also opined that Petitioner's right ankle progressed from an acute to chronic and permanent condition. He testified that Petitioner will always have some issues concerning swelling and stiffness of her right ankle, especially if wearing high heels or with prolonged standing.

Respondent did not produce any evidence rebutting Petitioner's evidence proving permanency. Based on the nature of Petitioner's right wrist/hand condition of ill-being; right forearm conditions of ill-being; right ring trigger finger condition of ill-being; and right ankle condition of ill-being, the Arbitrator finds that Petitioner sustained 35% permanent partial disability of her right hand (scapholunate tear and denervation); 10% permanent partial disability of her right arm (epicondylitis with recurrent tendinitis); 15% permanent partial disability of her right foot (chronic talofibular tear); and 10% permanent partial disability of her right ring finger (trigger finger).

Steven J. Fruth, Arbitrator

January 6, 2017

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KELLY KATHRENS,

Petitioner,

vs. NO: 11 WC 25689

UNIVERSITY OF ILLINOIS,

18IWCC0378

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses/prospective medical, temporary total disability (TTD), 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.

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; the Commission is bound by the record made at arbitration. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)).

By way of context in this claim, the issue of accident was in dispute at arbitration; Petitioner testified as to the work injury that occurred on July 16, 2009: "I was in the control room standing at the counter to fill out my time card; and a shift supervisor, the shift supervisor Ricki Broom attacked me from behind, pinned me against the counter and began to hit me in the back with

actions simulating sex." (T.9-10). Petitioner testified that Mr. Broom stood directly behind her, with both his arms on either side of her, and he "was bumping his waist against my buttocks." Petitioner stated that she could not get away, and that Mr. Broom had hit her approximately six times before "the panic took over." (T.10).

At arbitration, witnesses for both parties gave different descriptions of the incident. Petitioner's witness, Belle Brine (formally known as Bill Brine), testified that Mr. Broom appeared to be "scooting" past Petitioner, and in the process "was banging her up against the countertop"; Ms. Brine did not believe the act was sexual in nature. (T.100). Respondent's witness, David Boyd, also testified at arbitration; he stated that Mr. Broom was trying to pass behind Petitioner, and because there was very little room to do so, his stomach bumped against Petitioner as he walked out. (T.134-135; T.137; T.139). Mr. Boyd also believed that the contact was not sexual in nature. (T.159). With the evidence adduced at arbitration, the Arbitrator found that Petitioner was at work on July 16, 2009, performing her duties as instructed by Respondent [filling out her time card in the Control Room of the power plant during a shift change], when she was subjected to unwanted contact by her shift supervisor, Mr. Broom. The Arbitrator concluded that Petitioner suffered an accident that arose out of and in the course of her employment with Respondent. On Review, Respondent did not dispute the finding of accident.

As to causal connection, however, the Arbitrator found that Petitioner failed to prove that her diagnosis of post-traumatic stress disorder (PTSD) was causally related to the July 16, 2009 work accident. The Arbitrator noted that the parties were not disputing Petitioner's other alleged injury which consisted of bruising to her hips or pelvis area. The basis for the Arbitrator's Decision relative to causal connection was that the evidence was not sufficient to demonstrate "a person who was in fear for her life or serious bodily harm, which is one of the criteria required for a diagnosis of PTSD." The Arbitrator noted that Petitioner did not seek any medical treatment after the accident, and did not seek any mental health treatment until more than 17 months after the accident date. The Arbitrator did not find Petitioner to be credible.

The Arbitrator stated that compared to the other witnesses at arbitration, Petitioner's account of the accident was exaggerated. This "exaggerated version" was what her medical providers, Dr. Judy Osgood and Marie Pritchard, relied on in forming their opinions and their recommendations for treatment. The Arbitrator further indicated that the opinion of Dr. Wayne Stillings, Respondent's Section 12 examiner, was more compelling than Dr. Osgood's and Ms. Pritchard's, as Dr. Stillings was trained in forensic psychology and was a board certified forensic psychiatrist, while Dr. Osgood was not board certified and was not a forensic psychologist.

The Arbitrator did underscore that while Petitioner did suffer unwanted and improper contact, the evidence in the record was not sufficient to establish that Petitioner sustained PTSD as a result of the July 16, 2009 accident. Nonetheless, the Arbitrator did award 0.2% loss of the person as a whole for the bruising sustained by Petitioner; the Arbitrator did not award any further benefits.

In reviewing the record in its entirety, the Commission disagrees with the Arbitrator's assessment of the incident and the nature and extent of the injury sustained by Petitioner. The Commission, therefore, modifies the Decision, and finds that while Petitioner failed to prove that

she developed PTSD as a result of the July 16, 2009 accident, the evidence establishes that Petitioner developed anxiety and panic issues, in addition to her bruising, due to the unwanted and improper contact of the Respondent's employee, Ricki Broom.

With respect to the history of how our courts have analyzed mental trauma in workers' compensation claims, our Supreme Court first held in *Pathfinder Co. v. Indus. Comm'n* that psychological injuries could be compensable in either of two ways: (1) where the psychological injuries were related to and caused by a physical trauma or injury, *i.e.*, "physical-mental" trauma, or (2) where the psychological injuries were caused by "a sudden, severe emotional shock traceable to a definite time, place and cause which causes psychological injury or harm *** though no physical trauma or injury was sustained," *i.e.*, "mental-mental" trauma. 62 Ill. 2d 556, 563 (1976).

As a matter of first impression in our courts, the case of *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734 (4th Dist. 1997), resolved the issue of whether a supervisor's forcing of nonconsensual sexual intercourse upon an employee can constitute physical contact for purposes of establishing compensation for psychological injuries under the "physical-mental" theory. Our Appellate court answered in the affirmative, and further clarified that rape, sexual assault, and battery were all physical bodily injury crimes in Illinois. For purposes of battery and aggravated sexual assault, bodily harm may be shown by either actual injury, such as bruises, or may be inferred by the trier of fact based upon common knowledge. *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 739 (4th Dist. 1997). Under the "physical-mental" theory, the work-related physical trauma need not be the sole causative factor, but need only be a causative factor of the subsequent mental condition. *Id.* at 738.

Guided by *City of Springfield*, Petitioner's claim is classified as and should be analyzed under a "physical-mental" theory of recovery. Although Petitioner's claim does not rise to the level of the type of assault described in *City of Springfield* or in *Perez v. State of Illinois*, 2012 Ill. Wrk. Comp. LEXIS 1381, which the Arbitrator in the case at bar relied upon, it is not lost upon this Commission that Petitioner sustained some type of uninvited, unwanted, and improper physical contact by her shift supervisor, Mr. Broom – Petitioner, Petitioner's witness, Belle Brine, and Respondent's witness, David Boyd, each testified to this effect. Further, Respondent does not dispute that Petitioner sustained bruising to her hips or pelvis area following the July 16, 2009 accident.

The primary issue on Review is whether Petitioner suffered PTSD as a result of the July 16, 2009 accident, and if not, whether she sustained any other form of mental injury, temporary or permanent. Both Dr. Osgood, a licensed clinical psychologist, and Respondent's Section 12 examiner, Dr. Stillings, opined that Petitioner suffered from pre-existing depression; Dr. Stillings went on to state that he had reviewed Petitioner's prior medical records from 1987 and subsequent to the July 16, 2009 accident, and indicated that Petitioner also had longstanding, pre-existing personality problems. (PX15, pg. 67; RX3, pg. 13; 45). Neither Ms. Pritchard nor Dr. Osgood had any records or information concerning Petitioner's prior medical history; both of Petitioner's medical experts testified to not reviewing and having no documentation relative to Petitioner's prior medical history. (PX15, pg. 93; PX16, pgs. 62-64).

The Commission agrees with the Arbitrator in that Dr. Stillings is the more qualified doctor

in this claim; he was the only physician who rendered an opinion based on Petitioner's complete medical history. Dr. Stillings, therefore, relying on Petitioner's history and medical records, as a whole, together with the psychological testing and mental status examination, diagnosed Petitioner with pre-existing and recurrent major depressive disorder, as well as personality disorder with somatoform. He did not relate Petitioner's condition to the July 16, 2009 accident. (RX1; RX3, pgs. 21-22).

Dr. Stillings also emphasized that in PTSD cases, especially, one cannot rely on subjective complaints. "A self report is not reality. That's just the way the person is presenting. It doesn't mean that it's accurate or representative." (RX3, pg. 40). Thus, reliance on the objective evidence is ever the more imperative in this claim. At his deposition, Dr. Stillings discussed the tests he administered on Petitioner to reach his conclusions that Petitioner suffered no aggravation to any pre-existing mental condition and that her current condition was unrelated to the July 16, 2009 accident. Those tests were the MMPI-2, MCMI-III, the SIMS, the DCT, and validity tests. Dr. Stillings explained that the results of the tests pointed towards the hypochondriasis, hysteria, and psychopathic deviancy scales, which had nothing to do with PTSD, depression, or anxiety. (RX3, pg. 15; 17). Dr. Stillings opined that what Petitioner suffered from was a personality disorder which "are by and large untreatable." (RX3, pgs. 23-24).

Dr. Stillings also reviewed Dr. Osgood's medical records and noted that Dr. Osgood primarily relied on Petitioner's self-report; Dr. Osgood lacked a complete forensic psychiatric history, and the tests she performed, except the MMPI-2, had little forensic validity. (RX2). Dr. Stillings testified that although Dr. Osgood's MMPI-2 test findings were similar to his, "[h]er test pattern doesn't suggest PTSD at all. It suggests otherwise. She didn't have classic elevations on the PTSD scales." (RX3, pg. 26).

As to PTSD, Dr. Osgood provided the following explanation:

> What separates PTSD from other types of depression is that number one, there has been a traumatic event that the person experienced, witnessed or was confronted with, an event or events that involved actual or threatened death or serious injury of threat to them. And the response involved intense fear and horror, helplessness. And with PTSD then what separates that from depression is that as a result of that traumatic event, the person experiences like – can experience like nightmares of the traumatic event, the abuse; they can have flashbacks about it . . . That the person wants to avoid that experience, and avoid the thought, feelings or conversations around it, activities, places or people that arouse those recollections. (PX15, pgs. 103-104).

Dr. Stillings testified similarly, stating that the only complaint that would directly suggest PTSD were Petitioner's nightmares. However, Dr. Stillings stated that Petitioner's description of her nightmares was generalized. (RX3, pg. 30). A review of the record, specifically Petitioner's testimony at arbitration, demonstrated that Petitioner never specifically described her nightmares.

Considering further Dr. Osgood's definition of PTSD, wherein the individual experience involved actual or threatened death or serious injury of threat to them, and the response involved intense fear, horror, and helplessness, the evidence is lacking in this regard. The Commission finds that while Petitioner did suffer unwanted and improper contact on July 16, 2009, the Commission does not believe that the incident rose to the level of a life-threatening event or a threat of serious bodily harm. For example, Petitioner testified to feeling panicked after the accident; Ms. Brine stated that Petitioner seemed upset; and, Mr. Boyd testified that Petitioner continued to fill out her time card after the accident. As the Arbitrator pointed out, the evidence in the record does not portray a person who suffered from such intense fear for her life on the date of accident. Dr. Stillings also added that the fact that Petitioner worked for six months after the July 16, 2009 accident "would argue against PTSD." (RX3, pg. 41). Petitioner did continue to work until January 2010, when she was taken off work for an unrelated knee injury; she remained off work per her treating physician through the end of March 2011. (T.28).

Notwithstanding the foregoing, the Commission is nonetheless not convinced that Petitioner suffered absolutely no mental injury as a result of the unwanted contact by her supervisor, Mr. Broom. Belle Brine, Petitioner's witness, testified that after the July 16, 2009 incident, but before Petitioner left to treat her unrelated knee injury in January 2010, she had noticed that Petitioner was more withdrawn at work. (T.113). Respondent's witness, David Boyd, testified that after the accident, Petitioner had requested an order of protection against Mr. Broom. When that request was denied, Mr. Boyd noted that Petitioner began isolating herself. (T.161-162). The Commission also notes that Respondent's workforce is predominately male with a suggested culture of vulgarity. (T.94-95; T.146; PX16, pg. 13).

In consideration of the record thus far, the Commission finds that as result of the July 16, 2009 accident, Petitioner suffered bruising to her hips or pelvis area; she also developed anxiety and panic issues. Both Dr. Stillings and Dr. Osgood believed that Petitioner had pre-existing depression, and Dr. Osgood explained that someone with underlying depression, who then experiences a traumatic event, would be affected differently than someone who is not affected by an underlying mental disorder. (PX15, pg. 112). Based on the record, however, the effect of the July 16, 2009 incident was not PTSD.

In fact, as of January 2010, Petitioner had not sought any medical treatment for PTSD or any other mental condition. When Petitioner was eventually released back to work on March 31, 2011, following time off for her unrelated leg injury, Petitioner began specifically treating for her anxiety and panic issues as a result of returning back to work; the treatment included Xanax and a referral to Marie Pritchard, a licensed clinical social worker at New Dawn Counseling Center of Central Illinois. (T.31-33; T.53-54; PX1).

The Commission notes that when Petitioner returned to work in April 2011, she had sought and received an accommodation from Respondent. Petitioner had spoken with her direct supervisor, Mike Larson, and an agreement had been reached. "It was agreed that I would never be on Rick Broom's schedule. It was agreed that he would turn down overtime if it meant working the same shift that I was working." Petitioner testified that she was able to avoid Mr. Broom for the most part. (T.45-46). Petitioner performed her usual duties until she went off work on June 5, 2011 at the recommendation of Ms. Pritchard. In a July 26, 2011 letter, Ms. Pritchard explained

that she had diagnosed Petitioner with PTSD, and that this condition was the "direct result of being sexually assaulted in the work place." (PX2; PX16, pg. 12; 30; 54). Ms. Pritchard recommended that Petitioner remain off work; and Petitioner did in fact remain off work through September 23, 2013. (T.43; T.46; T.53; PX2; PX6).

Dr. Osgood had also diagnosed Petitioner with PTSD and depressive disorder. The Commission notes, however, that according to Dr. Osgood's November 15, 2011 report and at her deposition, Dr. Osgood based her diagnosis on Petitioner's description of continued abuse, sexual harassment, and discrimination, which caused Petitioner to re-experience the July 16, 2009 incident, and was thus, a re-traumatization.

In line with the Commission's earlier finding that Petitioner's injury, as a result of the July 16, 2009 incident, did not rise to the level of PTSD, the Commission does not find persuasive the basis of Dr. Osgood's diagnosis and opinion. Prior to the January 2010 unrelated leg injury, and after Petitioner returned to her full duties in April 2011, Respondent accommodated Petitioner wherein she would not work the same schedule as Mr. Broom; Respondent was willing to and in fact did continue this accommodation until Petitioner voluntarily resigned at the end of July 2014. (T.9; T.57). Petitioner even testified, "I was senior in my job classification. I was sent to work in water treatment so I was away from the main floor. Most of the people – and I only worked with one other employee who I had never had a problem with him." (T.60). The Commission also finds that the evidence is completely devoid of any alleged continued abuse, sexual harassment, or discrimination during this same time period of July 17, 2009 to January 2010 and April 2011 to July 2014.

Again, taking into account the specific diagnosis of PTSD, the Commission cannot causally relate Petitioner's alleged current condition of PTSD to the July 16, 2009 incident. Petitioner's alleged triggers are so remote from the July 16, 2009 incident and now include co-workers who were not present during the incident and people in general; books and resumes are also triggers because they remind Petitioner of work. (T.48; T.60; T.64).

In reliance of the foregoing, the Commission finds that Petitioner failed to sustain her burden of proving that her alleged current condition of ill-being, namely her putative PTSD diagnosis, is causally related to the July 16, 2009 accident. Given that any time off work was associated with Petitioner's alleged PTSD, which the Commission finds Petitioner failed to prove, the Commission further denies any award for TTD.

The Commission does find that as a result of the July 16, 2009 accident, Petitioner suffered bruising to her hips or pelvis area, and she developed anxiety and panic issues; and, though Petitioner continues to complain of anxiety and panic that has rendered her unable to leave her house, go outdoors, or confront the general public, this evidence, as explained above, fails to support a continuing causal connection to the work incident of July 16, 2009.

Accordingly, the Commission modifies the award for permanent partial disability (PPD), and finds that 10% loss of the person as a whole is a more proper award given the evidence as a whole. The Commission also awards Dr. Osgood's bill for her November 15, 2011 assessment and report in the amount of $1,920.00. (PX9).

18IWCC0378

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed October 17, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $552.74 per week for a period of 50 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused 10% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses totaling $1,920.00 pursuant to Sections 8(a) & 8.2 of the Act.

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

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

No bond is required for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: JUN 13 2018
MJB/pm
O: 05-14-18
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KATHRENS, KELLY
Employee/Petitioner

Case# **11WC025689**

UNIVERSITY OF ILLINOIS
Employer/Respondent

18IWCC0378

On 10/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% 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:

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CHAMPAIGN, IL 61825

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

OCT 17 2017

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

18IWCC0378

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

KELLY KATHRENS
Employee Petitioner

v.

UNIVERSITY OF ILLINOIS
Employer/Respondent

Case # 11 WC 25689

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 Urbana, on July 12, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On July 16, 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 $42,376.42; the average weekly wage was $921.23.

On the date of accident, Petitioner was 38 years of age, *single* 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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

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

ORDER

The Petitioner has failed to establish that her current condition of ill-being is causally related to the accident of July 16, 2009.

For the injuries sustained by the Petitioner as a result of the accident of July 16, 2009, Respondent shall pay Petitioner permanent partial disability benefits of $552.74 per week for one week, because the injuries sustained caused the 0.2% loss of the person as a whole, as provided in Section 8(d)(2) of the Act.

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

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

Edward Lee
Signature of Arbitrator

10/14/17
Date

OCT 17 2017

ARBITRATOR'S FINDINGS:

The Petitioner has alleged that she developed post-traumatic stress disorder as a result of a sexual assault by a co-worker on July 16, 2009. There is no dispute that the Petitioner was the recipient of unwanted contact from a co-worker on that date. Rather, the dispute at the center of this case focuses on the nature of that contact and its impact on the Petitioner's mental health. The Petitioner has failed to establish that the incident of July 16, 2009, resulted in a diagnosis of post-traumatic stress disorder.

TESTIMONY:

The Petitioner testified at length regarding the contact that forms the basis of this claim, as well as her symptoms and treatment following the incident of July 16, 2009. The Petitioner testified that she worked as an auxiliary Operating Engineer at Abbott Power Plant. (Arb. Tr., pg. 8). The Petitioner explained that she started working at the power plant in 1993, and voluntarily resigned in late July of 2014. (Arb. Tr., pg. 9). The Petitioner explained that the alleged sexual assault occurred in the Control Room. (Arb. Tr., pg. 19). At the time of the alleged assault, the Petitioner was filling out her time card during a shift change. (*Id.*). According to the Petitioner, "I was in the Control Room standing at the counter to fill out my time card; and a shift supervisor, Ricki Broom, attacked me from behind, pinned me against the counter, and began to hit me in the back with actions simulating sex." (Arb. Tr., pgs. 9-10). The Petitioner explained that she could recall at least six incidents of contact. (Arb. Tr., pg.10). According to the Petitioner, "The last hit I remember was hit number 6 because that's when the panic took over." (*Id.*). Following the attack, the Petitioner, "was in the middle of a full blown panic attack trying to collect myself and trying not to cry." (Arb. Tr., pg. 11). The Petitioner explained that, "He was hitting me hard enough that he left bruises on my hips from hitting the counter." (Arb. Tr., pg. 14). The Petitioner explained that she was physically injured as a result of this occurrence, but she declined to seek medical treatment. (Arb. Tr., pgs. 19-20).

The Petitioner explained that she explored several routes to have Mr. Broom disciplined for this incident. Despite those efforts, to the best of her knowledge, Ricki Broom was never disciplined in conjunction with this occurrence. (Arb. Tr., pg. 22). The Petitioner explained that she went to the Department of Human Resources and to the Office of Equal Opportunity and Access regarding this incident. (Arb. Tr., pgs. 22, 23). It was the Petitioner's expectation that Ricki Broom would be fired after she reported this incident. (Arb. Tr., pg. 25). Neither of those contacts resulted in any action or further investigation. (Arb. Tr., pgs. 23, 24).

Following the incident, the Petitioner continued to work in her regular position at the power plant. She eventually left the power plant in January of 2010, due to an unrelated right knee injury. (Arb. Tr., pg. 28). The Petitioner remained off work as a result of the knee injury, pursuant to her doctor's instructions, through the end of March of 2011. (Arb. Tr., pg. 28). During the period that the Petitioner was away from work, her condition "seemed to deteriorate." (Arb. Tr., pg. 28). Specifically, the Petitioner testified, "I was afraid of other people. I never wanted to leave the house. I had several episodes of panic attacks, terrible nightmares, flashbacks." (Arb. Tr., pg. 29). The Petitioner testified that she was terrified when she was released to return to work from the leg injury, on March 31, 2011. (Arb. Tr., pg. 30).

While the Petitioner was off work, she made additional attempts to seek help. She filed a complaint with the Equal Employment Opportunity Commission in February of 2010. (Arb. Tr., pg. 34). She also called the Rape Crisis Hotline and contacted the University of Illinois Police Department to file a police report. (Arb. Tr., pgs. 35, 37). The Petitioner testified that nothing came of the police report. (Arb. Tr., pg. 37). The Petitioner also filed an Order of Protection, at the urging of the rape crisis counselor. (Arb. Tr., pg. 38). That Order of Protection was denied. (Arb. Tr., pg. 38).

The Petitioner began seeking treatment with Marie Pritchard in March of 2011. (Arb. Tr., pgs. 40–41). Marie Pritchard is a licensed clinical social worker. (Arb. Tr., pg. 33). The Petitioner continued treatment with Marie Pritchard from March of 2011 through the date of the arbitration hearing. (Arb. Tr., pg. 41). The Petitioner explained that she did not seek any mental health treatment from July of 2009 through March of 2011 because, "I thought it would go away. I had absolutely no idea what was wrong with me." (Arb. Tr., pg. 42).

Following the resolution of her knee injury, the Petitioner returned to work in her regular position at the power plant from April of 2011 through June 5, of 2011. (Arb. Tr., pg. 43). During that period, the Petitioner testified that she was terrified, and her job performance was poor. (Arb. Tr., pg. 43). When she returned to work, she returned to the Office of Equal Opportunity and Access, requesting an accommodation that would allow her to work away from Ricki Broom. (Arb. Tr., pg. 45). The Petitioner testified that nothing came of that requested accommodation. (Arb. Tr., pg. 45).

As a result of increased anxiety at work, Marie Pritchard restricted the Petitioner from working from June 5, 2011, through September 23, 2013. (Arb. Tr., pgs. 46-47). During that time, the Petitioner continued to have trouble with anxiety. (Arb. Tr., pg. 47). The Petitioner testified that, as a result of this incident, "I became a recluse. My family did not understand the strange behavior. I have been disowned by my family and I have been disinherited by my family." (Arb. Tr., pg. 49).

The Respondent sent the Petitioner to be evaluated by Dr. Wayne Stillings for a Section 12 examination. The Petitioner testified that Dr. Stillings' examination was "terrible." (Arb. Tr., pg. 49). Specifically, the Petitioner testified that, "He said that he would stop the session if my friend didn't leave, and he yelled about everything. And whenever he would ask me a question and I did not answer it to his satisfaction he said I was being uncooperative and that he would stop the session and he was going to tell the University that he could not evaluate me." (Arb. Tr., pg. 50). Further, the Petitioner testified, "He insisted that I was on workman's comp and when I told him that I was not he screamed at me so loud that he got red in the face and called me a dirty little liar and said that he was going to call the University and the session was over. He went to call the University and of course they told him that I was on workman's comp and the entire time all he would do was threaten to stop the session. He insulted my family, and I told him what my father did for a living, that he was a farmer, and he called my father stupid." (Arb. Tr., pg. 51).

Before returning to work, the Petitioner applied for disability through the State University Retirement System. (Arb. Tr., pg. 56). That application was denied. (Arb. Tr., pg. 56). The Petitioner testified that she ultimately sought a work release from her primary care physician, Dr. Hoffman, in September of 2013 because she was broke. (Arb. Tr., pg. 56). After that release, the Petitioner returned to work and continued working until she voluntarily resigned in July of 2014. (Arb. Tr., pg. 57). The Petitioner testified that during that time, she was not doing a good job of performing her job duties. (Arb. Tr., pg.

57). The Petitioner further testified that if she had not resigned, she would not have been able to continue working in her regular position. (Arb. Tr., pg. 61).

The Petitioner testified that she has not worked again since her resignation because, "Work is where people hurt you." (Arb. Tr., pgs. 61-62). The Petitioner explained that she does not believe she is capable of working because, "I can barely leave my house." (Arb. Tr., pg. 62). Since resigning, the Petitioner has not even been able to complete her resume, as a result of symptoms of anxiety. (Arb. Tr., pg. 63).

The Petitioner explained that she continues to have symptoms related to this incident. (Arb. Tr., pg. 66). Specifically, the Petitioner explained, "I mean it gets so bad that I don't even want to take out the trash because that means going outside. All of my friends have pretty much dropped away. Of course my family wants nothing to do with me. I can't travel." (Arb. Tr., pg. 66).

On cross-examination, the Petitioner explained that Ricki Broom had pinned her to the table in the Control Room, with a hand on either side, preventing her escape. (Arb. Tr., pgs. 73-34). The Petitioner testified that there were at least seven people in the Control Room at the time of the incident. (Arb. Tr., pg. 72).

The Petitioner reiterated that she did not seek any treatment for mental health between July 2009 and March 2011. (Arb. Tr., pg. 77). During that time, she saw a number of doctors for her knee condition. (Arb. Tr., pg. 77). The Petitioner never mentioned complaints of anxiety or depression to any of those doctors. (Arb. Tr., pg. 77).

The Petitioner denied that she had any symptoms of depression or anxiety prior to the incident of July 16, 2009. (Arb. Tr., pg. 79). The Petitioner also testified that she never sought treatment for any mental health problems before July of 2009. (Arb. Tr., pg. 79). The Petitioner acknowledged that she was on medication for depression prior to July 16, 2009, but explained that it was prescribed to help control pain associated with sinus problems. (Arb. Tr., pg. 88).

The Petitioner claimed that she had never been involved in any type of physical assault, aside from the incident of July 16, 2009. (Arb. Tr., pg. 80). Later, the Petitioner acknowledged that she was mugged on August 26, 2008. (Arb. Tr., pg. 80). In that incident, she was hit on the right side of her face and on the right side of her ribs. (Arb. Tr., pgs. 80-81). Regarding that incident, the Petitioner explained, "At the time it was happening it was pretty scary, but it was over and I didn't have any residual problems." (Arb. Tr., pg. 81). The Petitioner testified that she sought medical treatment immediately after that assault, but did not seek any mental health care. (Arb. Tr., pgs. 81, 82). The Petitioner further testified that in January of 2016, a police officer roughly pulled her out of her vehicle and dropped her on her head. (Arb. Tr., pg. 82). As a result of that incident, the Petitioner suffered a concussion. (Arb. Tr., pg. 82). The Petitioner explained that she did not have a significant increase in her symptoms of her anxiety and isolation as a result of that incident. (Arb. Tr., pg. 83). The Petitioner differentiated the two other assaults from the assault that forms the basis of this case, because the others were "not sexual in nature." (Arb. Tr., pg. 84).

The Petitioner next called Belle Brine as a witness in support of her case. Brine testified that she previously worked at Abbott Power Plant for 29 years, retiring in March of 2012. (Arb. Tr., pgs. 92-93). Brine testified that she was employed as a Lead Operating Engineer in July of 2009, supervising

operations crews. (Arb. Tr., pg. 93). Brine testified that she was familiar with the Petitioner, and had worked with her for several years. (Arb. Tr., pg. 94).

Brine testified that she observed the event that forms the basis of this claim. (Arb. Tr., pg. 95). Specifically, Brine testified that she saw Ricki Broom pick up his backpack in the corner of the room to head out the door at the end of his shift. (Arb. Tr., pg. 99). Brine testified that, "The next thing I realize was Kelly was struggling to get herself off of this island. She was pushing away from it. He was behind her and I am like surprised." (Arb. Tr., pg. 100). According to Brine, Ricki Broom had one hand on his backpack and the other hand was in the air. (Arb. Tr., pg. 100). She explained that "he was banging her up against the counter top and she was – her immediate response was her hands were on the counter and she was pushing away. Next thing he is gone, he is out the door." (Arb. Tr., pg. 100). Brine further explained, "It happened in a matter of seconds, but he probably banged her up against the counter at least three times, and he was sort of waving his hand like he was riding a bull and he was rolling his eyes." (Arb. Tr., pg. 102). Brine estimates that Ricki Broom stood directly behind the Petitioner, without making an attempt to move toward the door, for 2½ or 3 seconds. (Arb. Tr., pg. 120). According to Brine, "It wasn't a sexual thing. It was more like he was putting on a show for an audience." (Arb. Tr., pg. 101). Brine did describe the incident "like groping." (Arb. Tr., pg. 108). Brine testified that there were probably 10 people in the room at the time this occurred. (Arb. Tr., pg. 101). Brine does not believe this was incidental contact, because "Rick already had a grudge against her and he already indicated that verbally to more than one person; and he also indicated verbally he had a problem with her standing there." (Arb. Tr., pg. 105). Brine saw the Petitioner's face at the time of the contact, and testified that the Petitioner appeared to be in pain. (Arb. Tr., pg. 107).

Following this incident, the Petitioner continued working on Brine's team. (Arb. Tr., pg. 111). Brine described the Petitioner's work performance as acceptable, noting that "I didn't really have any problems with her performance." (Arb. Tr., pgs. 111-112). During that period, Brine noted that the Petitioner's personality seemed a little bit more withdrawn. (Arb. Tr., pg. 113).

On cross-examination, Brine acknowledged that she was in a supervisory role at the time of this incident, but did not report it to anyone. (Arb. Tr., pg. 124). According to Brine, "I didn't know the extent of it at the time." (Arb. Tr., pg. 124). Continuing, Brine explained "It was not appropriate to me but I didn't know – I didn't realize it would grow into such a monster here." (Arb. Tr., pg. 124). Brine admitted that she did not like Ricki Broom, and believed him to be "arrogant and he wasn't a good leader and he didn't have the knowledge to be in the position he was in." (Arb. Tr., pgs. 124-125).

The only witness called to testify by the Respondent was Dave Boyd. Boyd was employed as a Lead Operator at the Abbott Power Plant in July of 2009. (Arb. Tr., pg. 127). Boyd was also present at the time of the incident that forms the basis of this case. (Arb. Tr., pg. 131). Boyd testified that this incident occurred during a shift change, and explained that the Control Room is busy during that process. (Arb. Tr., pg. 128).

Boyd testified that he witnessed Ricki Broom grabbing his book bag from a shelf. (Arb. Tr., pg. 134). According to Boyd, "When he passed by her he bumped her three times walking by her. He turned sideways and exited the room. When he got past her he squared up and was walking out and then walked out the side of the room over here." (Arb. Tr., pg. 134). According to Boyd, Ricki Broom never stopped

moving at any point as he was traversing the alleyway toward the door. (Arb. Tr., pg. 136). Further, Boyd testified that he saw Ricki Broom's feet the entire time. (Arb. Tr., pg. 136).

From his perspective, Boyd was also able to see the Petitioner. According to Boyd, "When he bumped her the first time, she stiffened and sort of looked aggravated and Rick, like I said, kind of bumped her sort of on the back over here and then kind of more squarely in the back and then maybe one time on this side, you know, and turned and walked on." (Arb. Tr., pg. 136). Boyd explained that it did not appear that these were forceful bumps. (Arb. Tr., pg. 137). Further, Boyd testified that it did not appear that the Petitioner was in pain. (Arb. Tr., pg. 137). Boyd explained, "She was irritated, but I couldn't see that she was in pain. She, I don't know, she didn't act like she was in pain." (Arb. Tr., pg. 137). Boyd testified that he did not perceive this contact as a simulated sex act. (Arb. Tr., pg. 159). Boyd testified that he saw Mr. Broom's right hand on his backpack, but did not see Broom's left hand. (Arb. Tr., pg. 138). If Broom's left hand would have been above his shoulder level, he would have been able to see his left hand. (Arb. Tr., pg. 138). After Broom passed, Boyd recalled that "She kind of cocked her head down and finished filling her timecard out, and I think she placed it on the counter up here right behind the Lead Operator, I think." (Arb. Tr., pgs. 138-139).

Boyd testified that the pathway where Broom came into contact with the Petitioner was narrowed by a chair that was sticking out. (Arb. Tr., pg. 140). According to Boyd, the chair arm was sticking out into the walkway, narrowing the area behind the Petitioner. (Arb. Tr., pg. 140).

On cross-examination, Boyd explained that he remembered this incident because there had previously been some conflict between Broom and the Petitioner. (Arb. Tr., pg. 144). Boyd testified that Broom had previously made a comment about the Petitioner's butt, and he thought it was poor judgment to come into contact with the Petitioner after that comment. (Arb. Tr., pg. 144, 147). Boyd further testified that there had been sufficient room for Broom to leave the area without contacting the Petitioner, if he had moved the chair or asked the Petitioner to move. (Arb. Tr., pg. 148, 149). Boyd explained that he had a conversation with Belle Brine after the incident, where Brine indicated she "was going to be the nail in Broom's coffin." (Arb. Tr., pg. 151).

EXPERT TESTIMONY:

At arbitration, the Petitioner submitted the transcript from the deposition of Marie Pritchard. (PX 16). Pritchard is a mental health therapist licensed by the State of Illinois. (PX 16, pg. 3). Pritchard has treated the Petitioner since March of 2011. (PX 16, pg. 6). When Ms. Pritchard initially saw the Petitioner, her treatment focused primarily on symptoms that aligned with post-traumatic stress disorder. (PX 16, pg. 8). Ms. Pritchard described the incident that led to the diagnosis of post-traumatic stress disorder. (PX 16, pg. 8). Specifically, Ms. Pritchard noted that "It was a fellow employee who, in a break room, grabbed her and turned her around and pushed her up against, like a counter or desk and made thrusting motions, and she said she couldn't get away." (PX 16, pg. 8). Ms. Pritchard testified that there was a delay between that incident and the initial treatment, stating that, "It had been a while before she came to see me." (PX 16, pg. 8).

Following the incident, the Petitioner told Ms. Pritchard that she felt unsafe and upset that the University didn't do anything. (PX 16, pg. 9). Ms. Pritchard noted that this was significant, explaining that the lack of a reaction from the University would impact the Petitioner as a "re-traumatization." (PX 16, pg. 10).

Based on the Diagnostic and Statistical Manual, Ms. Pritchard found that the symptoms described by the Petitioner allowed for a diagnosis of post-traumatic stress disorder. (PX 16, pg. 12). Ms. Pritchard testified regarding each of the criterion for a diagnosis of post-traumatic stress disorder, and found that the Petitioner met each one. (PX 16, pgs. 19-28). Ms. Pritchard explained that the Petitioner had not reported any other medications, substance abuse or illnesses that would explain her symptoms. (PX 16, pg. 28). Further, the Petitioner had not raised any other traumas that could explain the symptoms of post-traumatic stress disorder. (PX 16, pg. 31).

In October of 2013, Pritchard drafted a letter allowing the Petitioner to return to work. (PX 16, pg. 37). She was concerned about that return, because she thought the Petitioner would experience an increase in symptoms. (PX 16, pg. 38). Ultimately, Pritchard agreed that it was a good idea for the Petitioner to decide to leave the workplace. (PX 16, pg. 39).

Pritchard has continued to treat the Petitioner since her resignation at the University. During that time, the Petitioner's symptoms have not improved. (PX 16, pg. 39). Pritchard does not believe that the Petitioner is malingering or faking. (PX 16, pg. 43). Pritchard testified that "She is clearly miserable and distressed and not functioning well at all." (PX 16, pg. 41).

It is Pritchard's opinion that the assault is the traumatic event that spawned the post-traumatic stress disorder. (PX 16, pg. 54). This opinion is based on the Petitioner's report that she "felt like she was being held down and not being able to get away, feeling powerless, and the subsequent symptoms she shared that are attached to that event." (PX 16, pg. 54). Pritchard explained that she does not have an opinion whether the Petitioner's condition is "permanent in nature." (PX 16, pgs. 54-55). Nevertheless, it is Pritchard's opinion that the Petitioner requires continued treatment as a result of this assault. (PX 16, pgs. 55-56). Further, Pritchard does not believe that the Petitioner will ever be able to return to work in a place like the power plant. (PX 16, pg. 56).

On cross-examination, Pritchard acknowledged that the Petitioner never indicated that she had a history of any prior symptoms or treatment involving mental health. (PX 16, pg. 58). Further, Pritchard explained that prior symptoms and complaints would be relevant to her analysis of this case. (PX 16, pg. 58). Pritchard explained that she had not had any training in forensic psychology, and that her goal was to help the Petitioner, not to provide a diagnosis for purposes of a legal proceeding. (PX 16, pgs. 55, 56).

On cross-examination, Pritchard testified that the DSM IV-TR would have been the "gold standard" at the time Ms. Kathrens was diagnosed with PTSD. (PX 16, pg. 68). In that manual, it is noted that "malingering should be ruled out in situations in which financial remuneration, benefit eligibility and forensic determinations play a role." (PX 16, pg. 69). Pritchard acknowledged that she did not consider those factors in her treatment of Ms. Kathrens. (PX 16, pg. 69).

The Petitioner also presented the testimony of Dr. Judy Osgood. (PX 15). Dr. Osgood is a licensed clinical psychologist. (PX 15, pg. 4). She is not board-certified, and is not a forensic psychologist. (PX 15, pgs. 4-5). Dr. Osgood had studied forensic psychology, but had not completed those studies. (PX 15, pg. 5). Dr. Osgood saw the Petitioner for the limited purpose of completing a psychological evaluation, and did not provide any care or treatment in this case. (PX 15, pg. 9). Dr. Osgood testified that the

Petitioner "was seeking psychological care because of ongoing sexual harassment at work, and specifically a traumatic incident that happened in July 2009." (PX 15, pg. 14).

Dr. Osgood testified that the Petitioner provided a history of a traumatic incident. Specifically, "She reported to me that in July of 2009 that she was in the process, in a break room or something like that. But she was in a very small area. She stated that a supervisor, Ricki Broom, had bumped up against her and thrust against her, pinned her against the wall, and made several thrusts simulating sex. And that she was pinned against the wall and that she panicked. That she said 'ow' and that she – he continued, like there were several thrusts and I think she said approximately six. And there were other people in the room. And she said that he finally left. And she said that it was just – that she felt just helpless. That she felt very terrified. And that it was an extremely – very scary experience for her." (PX 15, pg. 19). According to Dr. Osgood, the significance of this incident was that "she was continuing to experience similar events of sexual harassment with the continued experience and perception that she had no control over it." (PX 15, pg. 24).

According to Dr. Osgood, at the time she was with the Petitioner, she exhibited symptoms of depression and anxiety that were consistent with PTSD. (PX 15, pg. 44). Dr. Osgood diagnosed the Petitioner with post-traumatic stress disorder and depressive disorder. (PX 15, pg. 60). This diagnosis was made after an extensive battery of tests. (PX 15, pgs. 52-54, 57). Dr. Osgood testified that she does not believe that the Petitioner was malingering or faking. (PX 15, pg. 90).

The Respondent presented the transcript from the deposition testimony of Dr. Wayne Stillings. (RX 3). Dr. Stillings is a board-certified forensic psychiatrist. (RX 3, pg. 4). Dr. Stillings testified that he sees and treats patients with symptoms of depression, anxiety and post-traumatic stress disorder. (RX 3, pg. 5). In this case, Dr. Stillings completed a standard forensic lifetime history for the Petitioner. (RX 3, pg. 7).

Dr. Stillings testified that the diagnosis of PTSD in this case is inconsistent and unsupported by diagnostic, independent and objective psychological testing. (RX 3, pg. 9). In conjunction with his examination, Dr. Stillings reviewed medical records from prior to the alleged occurrence, including records indicating psychological issues. (RX 3, pg. 12).Specifically, Dr. Stillings testified that the pre-accident medical records document that the Petitioner had nightmares prior to this work occurrence. (RX3, pg. 13). Those pre-accident medical records further "support the test findings, the objective test diagnostic findings that this person has a lot of longstanding personality problems, and maybe she has had some secondary depression along the way or primary depression as well, but her problems, there is really little support that her problems are related to this work occurrence." (RX 3, pg. 13). In conjunction with the history he took from the Petitioner, his examination indicates that the Petitioner "has chronic, longstanding pre-existing, meaning prior to the work occurrence, psychiatric problems, and she has a fairly strong propensity to express her psychological problems as physical subjective complaints that then get the attention of multi-specialist physicians." (RX 3, pg. 14).

Dr. Stillings completed an MMPI-2 testing in conjunction with his examination. (RX 3, pg. 15). Dr. Stillings explained that this is a 567-question test, which has been in use for over 70 years. (RX 3, pg. 15). Dr. Stillings noted that it was critical to use the correct context and profile to evaluate the Petitioner's responses. (RX 3, pg. 16), In this case, Dr. Stillings evaluated the test responses using a special forensic setting based on a control population with other people with legal claims. (RX 3, pg.

16). Based on that testing, the results suggested "an extreme attempt by this individual to present herself as being free of psychological problems in order to influence the outcome of her pending litigation." (RX 3, pg. 17). According to Dr. Stillings, individuals with this pattern "appear to consciously distort their responses to create the impression that they are extremely moral and virtuous and have no personal shortcomings." (RX 3, pg. 17). The test results further suggested that the Petitioner was not experiencing PTSD or anxiety. (RX 3, pg. 17). Finally, based on these results, Dr. Stillings concluded that "there is a possibility that this individual is obtaining considerable secondary gain from her symptoms at this time; her symptoms may be allowing her to avoid unpleasant activities or to gain other benefits." (RX 3, pg. 18).

Dr. Stillings ultimately diagnosed the Petitioner with major depressive disorder, recurrent, pre-existing, which is defined as prior to July 16, 2009. (RX 3, pg. 21). Dr. Stillings also diagnosed personality disorder, not otherwise specified, with somatoform passive-aggressive, histrionic, obsessive compulsive and narcissistic personality trait, pre-existing. (RX 3, pg. 21). Dr. Stillings does not believe that any of these conditions are causally related to the claimed incident of July 2009. (RX 3, pg. 22). Dr. Stillings concluded that none of the treatment the Petitioner received was causally related to the incident of July 2009, and that the Petitioner did not require any work restrictions as a result of the claimed incident of July 16, 2009. (RX 3, pgs. 22-23).

In this case, Dr. Stillings disagreed with the conclusions of Marie Pritchard, noting that she "didn't do any psychological testing, no objective personality diagnostic testing, certainly not a regular forensic evaluation." (RX 3, pg. 11). He further noted that Dr. Osgood's diagnosis of PTSD, based on the MMPI-2 results, constitutes a "misinterpretation of the clinical scales." (RX 3, pg. 26). Dr. Stillings concluded that, "In litigation, PTSD is grossly over-diagnosed because some mental healthcare professionals are not careful in applying objective criteria to support that diagnosis, and anybody can read about it on the internet and suggest that to somebody." (RX 3, pgs. 29-30).

EVIDENCE:

The Petitioner included a copy of the University of Illinois Accident Report with her trial exhibits. (PX 10). That report includes a complaint of "several incidents of discrimination, sexual harassment, retaliation for reporting sexual harassment, battery of a sexual nature by a supervisor." (PX 10). In the portion of the form for the accident date, the Petitioner indicates "diagnosed April 2011." (PX 10). The Petitioner wrote that she reported the incident to Mike Larson on April 26, 2011. (PX 10). The Petitioner signed the report on May 3, 2011. (PX 10).

The Petitioner also submitted a copy of notes made by Rob Roman around the time of the accident. (PX 11). Those notes reflect that the Petitioner told him "that during the previous weekend, she was in the north Control Room filling out her time card. Broom brushed up against her, then repeated it several times." (PX 11). The notes include a quote from the Petitioner that Broom "dry humped me like a dog." (PX 11). Finally, the notes reflect that the Petitioner "was not wanting a formal complaint to be filed. She did ask again that I talk to him and ask that he stop his remarks and actions." (PX 11). The notes from the following day reflect a conversation with Rick Broom. (PX 11). Roman wrote that Broom's "physical actions were not meant to be of a sexual nature, but he can see how they may be construed as such." (PX 11).

The Petitioner also included a copy of her Petition for a Civil No-Contact Order against Ricki Broom. (PX 12). That exhibit includes a narrative authored by the Petitioner. (PX 12). The narrative includes a description of the incident with Broom, consistent with the Petitioner's testimony. (PX 12). The narrative also includes a timeline, indicating that the Petitioner's complaint with the EEOC was filed on February 10, 2010, with initial contact with the Office of Equal Opportunity and Access occurring on May 5, 2010. (PX 12). This narrative also indicates that the Petitioner contacted the Rape Crisis Hotline in May of 2010 and filed a police report on June 1, 2010. (PX 12).

Finally, the Petitioner submitted a copy of her SURS disability application. (PX 14). That application reflects that the last date the Petitioner worked was June 7, 2011. (PX 14). On the forms, the Petitioner complains of "sexual assault and battery – attacked by Rick Broom." (PX 14). The form was signed by the Petitioner on November 16, 2011. (PX 14).

The Respondent's exhibits included a copy of Dr. Stillings' report of September 21, 2011. (RX 1). Dr. Stillings' report includes the Petitioner's explanation of the incident from July of 2009:

> "She alleged that RB 'grabbed me, spun me up against the counter' in front of coworkers, and made 'lude and lascivious actions.' She further stated that he 'slammed' against her from behind six times and his left hand touched her. She explained, 'He grabbed me by the waist' and 'He touched my rear end, too.' Her response was 'shock.'"

Dr. Stillings' report also included a review of pre-accident medical records. (RX 1, pg. 6). Those pre-accident records included references to nightmares, a hospitalization for Dextromethorphan overdose, a diagnosis of possible depression, and notations that the Petitioner appeared depressed on examination. (RX 1, pg. 6).

Dr. Stillings' report also includes his review of the transcript from the Petitioner's hearing for a Civil No-Contact Order. (RX 1, pgs. 8-10). George Bryan indicated that he was in the Control Room when the incident took place, and recalled Broom "made contact with her buttocks and said, 'Excuse me Kelly;' RB was shuffling and moving through the area, so there was some bumping; felt RB was just being rude." (RX 1, pg. 9). Dr. Stillings' notes regarding Dave Boyd's testimony were consistent with Boyd's testimony at trial. (RX 1, pg. 9). Dr. Stillings' notes also indicate that Rick Clark was present at the time of the incident. (RX 1, pg. 9). Dr. Stillings recorded that Rick Clark testified that it was common to bump into one another at shift change and that the Petitioner did not struggle or seem to be in pain when she was contacted by Broom. (RX 1, pgs. 9-10). Finally, Dr. Stillings noted that Rick Broom testified that he did not touch the Petitioner with his hands, did not thrust his pelvis into her buttocks and did not simulate any sort of sexual act. (RX 1, pg. 10).

The Respondent also submitted several medical records from Carle Clinic and Carle Hospital at the time of arbitration. (RX 4). These records include a notation that the Petitioner had complained of possible troubles with depression. (RX 4, pg. 8). There is also a reference to a recent hospitalization for Dextromethorphan overdose. (RX 4, pg. 13). In March of 2005, the Petitioner's primary care physician noted that, "She looks depressed to me. She seems like she is about to cry from time to time." (RX 4, pg. 13). In October of 2006, the Petitioner's primary care physician noted that, "I would like her to do some serious thinking about whether depression might be at the root of some of her troubles; and if so,

we should start her on anti-depressant." (RX 4, pg. 27). These records also include treatment following the two physical assaults referenced in the Petitioner's testimony. (RX 4, pg. 40; RX 5, pg. 5).

FINDINGS ON DISPUTED ISSUES:

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

The arbitrator finds Petitioner failed to prove her current condition of ill-being and the diagnosis of PTSD is causally related to the July 16, 2009 work accident. There is no dispute the Petitioner had a work accident which resulted in bruising to her hips or pelvis. However, the arbitrator finds the diagnosis of PTSD and all treatment related to the PTSD diagnosis is not causally related to the July 16, 2009 accident.

The medical records and Petitioner's testimony do not demonstrate a person who was in fear for her life or serious bodily harm, which is one of the criteria required for a diagnosis of PTSD. The Petitioner did not seek any medical treatment after the accident, and did not seek any mental health treatment until over 17 months after the accident. The arbitrator finds that the Petitioner's testimony was not credible and that the diagnosis of PTSD is unsupported by the evidence.

The Petitioner's description of the incident that forms the basis of this case is wildly exaggerated, relative to the recollection of each of the other witnesses. The Petitioner recalled violent thrusting and an attempt to restrain her movement. The other witnesses testified that there was certainly some unwanted contact, but without the forceful nature depicted by the Petitioner.

The Petitioner repeated this same exaggerated version of events to both Dr. Osgood and Marie Pritchard. Both Osgood and Pritchard then relied upon the accuracy of those events in forming their opinions. As a result, the foundation of those opinions can be called into question. The weight afforded to the opinions of Osgood and Pritchard is further reduced by the fact that they failed to consider and account for the Petitioner's pre-existing history of depression. Finally, neither Osgood nor Pritchard have been trained in forensic psychology. For all of these reasons, the arbitrator finds the opinions of Dr. Stillings more compelling than those of Osgood or Pritchard.

The description of this event by Dave Boyd and Belle Brine is fairly consistent. There is no dispute that unwanted contact occurred. Boyd testified that the Petitioner appeared annoyed, but did not seem to be in pain. Belle Brine testified that the Petitioner seemed to be experiencing pain, but she also expressed that she did not think the contact was so serious that it warranted any further action on her part. Moreover, Brine acknowledged that she did not like Ricki Broom, and even told Dave Boyd that she was going to be "the nail in Broom's coffin."

The arbitrator finds that the contact between Ricki Broom and the Petitioner is insufficient to support a diagnosis of PTSD. In fact, the Petitioner's actions after the alleged accident are consistent with the contact being nothing more than an annoyance. The Petitioner did not seek any medical or mental health treatment. In speaking to Rob Roman after the accident, it appears the Petitioner's primary motivation was to make sure that Broom was disciplined for his actions. She even told Roman that she did not want a formal complaint made against Ricki Broom. Finally, the lack of a significant response

to the Petitioner's complaints by way of various agencies would suggest that this was not a significant transgression.

The facts of this case can be favorably compared to those in *Perez v. State of Illinois*, 12 IWCC 1272 (2012). In *Perez*, the Petitioner was employed in a correctional facility as a dietary clerk. *Id.* An inmate tried to penetrate her genitals with his fingers and she engaged in a physical struggle with the inmate. *Id.* After that incident, the Petitioner had a breakdown at work, and was anxious and scared. *Id.* In denying the Petitioner's claim for PTSD, the Commission noted that the Respondent's expert "exhibited a better grasp of the current trends and assessments for the diagnosis of PTSD than did" the Petitioner's expert. *Id.* The Commission also explained that the Respondent's expert based his opinions on "a myriad of apparently objective tests, the results of which, cast considerable doubts as to the diagnosis of PTSD." *Id.* Most importantly, the Commission noted that it was "persuaded by the fact that the Diagnostic and Statistical Manual specifically provides that for PTSD to be diagnosed, the patient 'has to be in an immediately life-threatening scenario where there is the threat of death' or where there is a threat of severe harm." *Id.* The Commission concluded that "while Petitioner clearly did suffer a very disturbing assault, the Commission does not believe it rises to the level of a life-threatening event with the threat of death or great bodily harm." *Id.* Benefits were denied based on the Petitioner's failure to sustain her burden of proving that the work incident caused her current condition of ill-being. *Id.*

The rationale utilized by the Commission in the *Perez* case equally applies to the case at bar. The contact suffered by the Petitioner was unwanted and improper. Nevertheless, this is insufficient to establish that the Petitioner is suffering PTSD as a result of the accident of July 16, 2009. As a result, the arbitrator concludes that the Petitioner's current condition of ill-being is not causally related to the claimed accident.

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 was subjected to unwanted contact from Ricki Broom on July 16, 2009. At the time, the Petitioner was filling out her time card, as was required during shift changes. The Petitioner was in the Control Room of the power plant at the time of the accident, which was the typical location for completing that task. As such, the arbitrator finds that the Petitioner suffered an accident that occurred and arose out of and in the course of her employment with the University of Illinois.

J. Were 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 Respondent has paid all appropriate charges for all reasonable and necessary medical services and is not liable for the remaining outstanding medical bills. For the reasons discussed above, Petitioner failed to prove her current condition of ill-being and the diagnosis of PTSD are causally related to the July 16, 2009 work accident. Therefore, any outstanding medical bills for treatment of the PTSD diagnosis are also not related. Based on the foregoing, the arbitrator finds Respondent has paid all appropriate charges for all reasonable and necessary medical services and is not liable for the remaining outstanding medical bills.

K. What temporary benefits are in dispute? ☐ **TPD** ☐ **Maintenance** ☒ **TTD**

The arbitrator finds Petitioner is not entitled to and Respondent is not liable for TTD and/or maintenance benefits for the period of time the Petitioner was authorized off work for the PTSD diagnosis. For the reasons discussed above, Petitioner has failed to prove her current condition of ill-being and the diagnosis of PTSD are causally related to the work accident of July 16, 2009.

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

The Petitioner suffered nothing more than some bruising as a result of the work accident of July 16, 2009. She never sought treatment for this bruising, and she never mentioned the bruising to any of her physicians until several months after the accident. The arbitrator finds that these injuries warrant an award of $552.74, on the basis of 0.2% loss of use of a person as a whole, pursuant to Section 8(d)(2) of the Act.

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JKG/dkl
32868514_1

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

KENNETH MARZULLO,

Petitioner,

vs. NO: 15 WC 24679

CITY OF CHICAGO,
DEPARTMENT OF TRANSPORTATION,

18IWCC0379

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 the nature and extent of Petitioner's disability and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

After reviewing the record, the Commission agrees with the Decision of the Arbitrator and the award of 40% man-as-a-whole. In his Decision, the Arbitrator found that the Petitioner failed to prove a wage differential as he chose to stop the vocational rehabilitation plan and proceed to trial. Therefore, his claim for a wage differential award was denied. While the Commission agrees with the ultimate Decision of the Arbitrator, relative to a proper award under Section 8(d)2 of the Act, the Commission disagrees with the Arbitrator's reasoning for the denial of the wage differential award under Section 8(d)1 of the Act.

The Commission finds Petitioner not credible relative to his job search and his desire to return to work. It is because of this finding, the Commission finds that the Petitioner failed to prove an entitlement to a wage differential award.

If we are to follow the argument of the Petitioner, it matters not whether this or any Petitioner is sincere in his efforts at re-employment. Rather, we should only be concerned that

sufficient information is presented at hearing, demonstrating the difference between what Petitioner previously earned and what someone with similar restrictions might earn in the present job market. If such is the case, why then bother with any vocational rehabilitation efforts. Why not hire a vocational counselor and let that expert speculate as to the earning capacity of the Petitioner? The Respondent can then hire an equally speculative expert to give an opinion more favorable to its cause.

Petitioner appears to be relying upon the language of the Court in *Crittenden v. Ill. Workers' Comp. Comm'n*, 2017 IL App (1st) 160002WC, 73 N.E.3d 654, 2017 Ill. App. LEXIS 104, 411 Ill. Dec. 570, as the basis for his theory. The case at bar is readily distinguishable from *Crittenden*, as there, the Court indicated that Petitioner's entitlement to a wage differential award was no longer an issue. Here, the Respondent has consistently contested the efficacy of an award under Section 8(d)1 of the Act and contended that a PPD award pursuant to Section 8(d)2 of the Act is more appropriate.

Recent Decisions of the Appellate Court seem to direct our focus away from the circumstances surrounding the claim for an 8(d)1 award, but we believe that that was not the Court's intent. Rather, we believe that the Act still requires that the Petitioner prove not only an entitlement to the wage differential, but also a bona fide effort to return to suitable employment. This Petitioner, Marzullo, failed miserably in that regard.

Section 8(d)1 provides in pertinent part:

> If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment he shall, ...receive compensation for the duration of his disability...., equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident.

If the Commission is to follow the argument of the Petitioner, this would be a simple arithmetical calculation premised merely upon the conjecture of a vocational expert. There would be no need for testimony from the Petitioner and there would be no need for the Commission to have Rule 9110.10, setting forth the requirements for vocational rehabilitation. 50 Ill. Admin. Code, Section 9110.10, formerly Section 7110.10.

Neither Section 8(d)1 nor the Commission Rule on vocational rehabilitation create the illusion that the entitlement to a wage differential award is premised upon a simple arithmetical calculation. Rather, the Act and the Rule require that the parties cooperate in the rehabilitation of the Petitioner, such that he or she is able to reach the highest level of available employment.

The employer is expected to expend resources that allow the Petitioner to complete a vocational assessment, job training, a job search and eventual re-employment. The injured

employee is required to devote sufficient time and effort in this process to maximize the probability that he or she will return to gainful employment.

After reviewing the vocational progress reports, the Commission questions the sincerity of this Petitioner. It questions his sincerity for a multitude of reasons.

The Petitioner informed a prospective employer that 30 miles was too far for him to commute to a new job. In today's economy, a 30-mile commute is not inordinate.

During his vocational efforts, Petitioner did not complete follow-up calls with prospective employers. This was a requirement of his vocational rehabilitation plan. No explanation was given for his failure to make these calls.

The vocational counselor indicated in his reports that the Petitioner was "resistant" to attending hiring events and stated to the counselor, "I don't' know how I'm going to feel tomorrow, it depends on how I sleep tonight." When Petitioner did attend a job fair for a Fire and Safety Service Sales Representative position, on December 1, 2016, he informed the vocational counselor that he was not interested in a commission-based job, thus eliminating possible employment.

This Petitioner's comments relative to his job search reflect a continuing negative attitude. He voiced that he did not like being a "hobo" or "begging for a job." No one expected the Petitioner to become a "hobo" or to "beg for a job." But, it was anticipated that he would give a good faith effort to secure suitable employment.

Finally, the Commission is left to consider Petitioner's failure or refusal to complete and file any of the forms required for him to receive an accommodation for employment with the City of Chicago, his employer. When asked if he did so, he stated no. Certainly, such an effort is not so onerous that the Petitioner's failure to do so should be ignored and not work against his cause.

The Commission finds that Petitioner's efforts during vocational rehabilitation were at best suspect and at worst demonstrate a desire not to return to work. The Commission is left with the belief that Petitioner's efforts were merely gamesmanship that was intended to kite the value of an award rather than provide Petitioner with suitable re-employment.

It is the Commission's impression that Petitioner was not providing a good faith effort to secure employment during vocational rehabilitation. The Petitioner's conduct throughout this process demonstrates a refusal to acknowledge the importance and requirements of rehabilitation efforts. Accordingly, the Commission finds Petitioner not credible relative to his job search and vocational rehabilitation effort.

Since the Commission has no faith in the efforts of this Petitioner in the vocational rehabilitation process, it finds that he is not credible. It is that lack of credibility that requires that the Commission deny Petitioner benefits under Section 8(d)1 of the Act.

It is for these reasons that the Commission finds Petitioner failed to prove an entitlement to a wage differential award under Section 8(d)1 of the Act.

18IWCC0379

IT IS THEREFORE ORDERED BY THE COMMISSION, that the Decision of the Arbitrator filed May 4, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 200 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused 40% loss of the person as a whole.

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

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

The party commencing the proceedings 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 13 2018

MJB/tdm
O: 5-1-18
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARZUIIO, KENNETH
Employee/Petitioner

Case# **15WC024679**

CITY OF CHICAGO
Employer/Respondent

18IWCC0379

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

If the Commission reviews this award, interest of 0.97% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1987 RUBIN LAW GROUP LTD
CATHERINE K DOAN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

0010 CITY OF CHICAGO DEPT OF LAW
HOLLY ANDERSON
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kenneth Marzullo
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # **15 WC 24679**

18IWCC0379

An *Application for Adjustment 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 **March 23, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 14, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**78,521.56**; the average weekly wage was $**1,510.03**.

On the date of accident, Petitioner was **59** years of age, *single* with **no** dependent children.

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

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

Respondent shall be given a credit of $**44,008.92** for TTD, $**0** for TPD, $**50,337.00** for maintenance, and $**0** for other benefits, for a total credit of $**94,345.92**.

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 $**735.37**/week for **200** weeks, because the injuries sustained caused the **40%** 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.

Nathan Black

Signature of Arbitrator

May 3, 2017
Date

ICArbDec p. 2

MAY 4 – 2017

FACTS

The parties proceeded to hearing on March 23, 2017. The disputed issues were causation and the nature and extent of the injury.

On April 14, 2015, Petitioner was working as a laborer in Respondent's Department of Transportation. Petitioner testified that on April 14, 2015, he was attempting to remove a pin with a pry bar when he felt a pop in his right shoulder. Petitioner reported to Mercy Works that same day, where he was initially diagnosed with a right shoulder strain. (Px 1). On May 26, 2015, Petitioner underwent an MRI. (Px 2). The MRI showed the following:

1. Severe osteoarthritic changes of the shoulder with labral degeneration and large subchondral erosions.
2. Severe tendinopathy of the supraspinatus and infraspinatus with under surface tear at the junction of both tendons. Adjacent associated calcific tendinopathy indicates chronic rotator cuff disease with healing.
3. Moderate tendinopathy of the subscapularis and biceps tendon. Associated joint effusion.

Petitioner began treating with Dr. Brian Cole on June 22, 2015. (Px 3). Dr. Cole noted a work related injury and diagnosed glenohumeral arthritis, advanced, as well as acromioclavicular joint arthritis and partial rotator cuff tendinosis. He underwent a cortisone injection on June 22, 2015. Petitioner returned to Dr. Cole on August 3, 2015, and reported no substantial relief from the injection. At that time, Dr. Cole recommended a right total shoulder arthroplasty.

Petitioner underwent a right total shoulder replacement surgery on September 29, 2015. (Px 5). Thereafter, participated in physical therapy (Px 4) and continued to follow up with Dr. Cole. (Px 3).

On April 2, 2016, Petitioner underwent a functional capacity evaluation at Athletico, which placed him at the Heavy physical demand level, finding he could occasionally lift floor to waist 75 pounds, waist to shoulder 25 pounds, overhead 25 pounds, and carry 40 pounds for 30 feet. (Px 6). On April 4, 2016, Petitioner returned to Dr. Cole, who placed Petitioner at maximum medical improvement with permanent restrictions consistent with the findings of the functional capacity evaluation. (Px 3).

Petitioner began vocational rehabilitation services with Vocamotive on June 20, 2016. At that time, rehabilitation counselor Joseph Belmonte opined, "Mr. Marzullo has a current wage earning potential of between Minimum Wage and approximately $15.00 per hour. With the development of alternative skill sets, it may be possible to increase wage earning potential to between $15.00 and $20.00 hourly." (Px 7). Petitioner's work history included approximately 9 years as a dockworker and 7 years as an order writer in a grocery chain frozen foods department. Additionally, he had been OSHA certified to operate a forklift.

In June 2016, Petitioner began working on the Rehabilitation Plan outlined by Mr. Belmonte by focusing on development of computer literacy. (Px 7). On July 19, 2016, Petitioner underwent vocation evaluation testing services with rehabilitation counselor Steven Blumenthal. (Px 8). Mr. Blumenthal noted that Petitioner had substantially above average reading vocabulary and above average reading comprehension, and post high school spelling ability. (Px 8).

Petitioner testified that he had 8 interviews during his job search. Petitioner testified that he attended job fair. Petitioner testified that he did not apply for any jobs at a job fair, because no jobs were available. He went on to testify that all the jobs that were offered were commission only.

On December 20, 2016, Petitioner had an interview with U.S. Foods. (Px 7, pp. 93-94). Petitioner testified that he told the interviewer that the location was too far from his home. The location of the job was 30 miles from Petitioner's home.

On January 3, 2017, Petitioner had a phone interview for a job at Lurie Children's Hospital. (Px 7, p. 105). The interviewer was concerned about the $15.00 per hour salary amount, which Petitioner indicated on his application. Petitioner reported he told the interviewer that he would need to "take a little bit to think it over." Following the interview, Vocamotive assisted Petitioner in sending an email to the interviewer indicating that salary was not an issue.

Petitioner testified that he focused primarily on applying for jobs in the inventory control field. He testified that he applied for 2 jobs at grocery stores towards the end of his job search. The jobs he applied for generally offered to pay $13.00 to $15.00 per hour. Petitioner did not receive any offers of employment during his time job searching.

In Mr. Belmonte's March 13, 2017 progress report, he stated:

At this time, it is the determination of this consultant that there is an effective labor market available to Mr. Marzullo consistent with his physical capacities, work experience and educational level. As noted above opportunities for employment are consistently identified and interview opportunities to result.

It is recommended that vocational rehabilitation continue as currently targeted for another 30 days.

***

The previous rehabilitation plan remains in effect at this time.

Date of Next Report: April 13, 2017
(Px 7, p. 131).

Petitioner chose to proceed to a final hearing on March 23, 2017.

Petitioner's earlier position as a laborer, under Local Union 1001, has a current rate of pay of $40.20 per hour (Px 8).

Petitioner testified that he has stiffness and soreness in his right shoulder. Petitioner testified that he takes over the counter medication Tylenol for pain approximately two times per week. Petitioner testified that he has had to modify some of his daily routines, such as using his left hand to vacuum and generally becoming more dependent on his left hand. Petitioner is right hand dominant.

CAUSATION

The testimony of Petitioner and the medical records support a causal relationship. Dr. Cole noted a work related injury. The sequence of events is consistent. There is no evidence of a subsequent injury.

Based upon the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the accident.

NATURE AND EXTENT

Petitioner claims wage differential benefits.

Petitioner participated in vocational rehabilitation until March 13, 2017. At that time, Mr. Belmonte stated that Petitioner should remain in vocational rehabilitation, as there was an effective labor market available. Petitioner was receiving maintenance benefits. However, Petitioner chose to stop the vocational rehabilitation plan, and 10 days later he proceeded to a final hearing.

Based upon the foregoing, the Arbitrator finds that Petitioner did not complete the vocational rehabilitation plan. Therefore, Petitioner's claim for wage differential benefits is denied.

It is unrebutted that Petitioner is unable to return to his previous trade as a laborer. Therefore, the Arbitrator finds that Petitioner has sustained a loss of trade.

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:

The Commission shall base its determination on the following factors:

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

Neither party submitted an AMA impairment rating. Petitioner was a laborer for the City of Chicago, which is heavy work. Petitioner was 59 years old at the time of the accident, and he sustained a loss of earning capacity. The medical records corroborate that physical restrictions are permanent. Petitioner's restrictions and current complaints of pain are relatively moderate.

Based upon the foregoing, the Arbitrator finds that the Petitioner has sustained a 40% loss of use of the person as a whole.

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

Vicki S. Ginoli,
Petitioner,

vs. NO: 13WC 18792

State of Illinois Department of Revenue,
Respondent.

18IWCC0380

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 31, 2017, is hereby affirmed and adopted.

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

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

No bond or summons required for State of Illinois cases.

DATED: JUN 13 2018
o060418
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GINOLI, VICKI S
Employee/Petitioner

Case# **13WC018792**

STATE OF ILLINOIS DEPT OF REVENUE
Employer/Respondent

18IWCC0380

On 10/31/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.26% 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:

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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

OCT 31 2017

Richard A. Pasula, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Vicki S. Ginoli
Employee/Petitioner

v.

State of Illinois Department of Revenue
Employer/Respondent

Case # **13** WC **018792**

Consolidated cases: **N/A**

18IWCC0380

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **August 29, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 14, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$57,597.80**; the average weekly wage was **$1,107.65**.

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

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

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

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

Respondent is entitled to a credit for all medical benefits paid through its group health carrier for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove she sustained an accident on April 14, 2011 that arose out of and in the course of her employment or that her condition of ill-being in her bilateral elbows was causally connected to her employment duties for Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

October 25, 2017
Date

Vicki S. Ginoli v. State of Illinois Dept. of Revenue, 13 WC 18792

Findings of Fact and Conclusions of Law

Petitioner alleges that she developed bilateral cubital tunnel syndrome on April 14, 2011 due to her job duties with Respondent. (AX 2)

The Arbitrator finds:

Petitioner began working for Respondent on September 18, 1978. (RX 1) For the first five years of her employment, she worked in a data entry department keyboarding. She then moved to "documents control deposit" for 10 to 12 years which also involved keyboarding. Thereafter for approximately six years she worked in "electronic funds" performing keyboarding activities. That was followed by work for "IPD" (the Individual Processing Department) where she would go to a shelving unit and pick up 30 to 50 pound buckets of work. During that time her hands started going numb and she had to shake them out. (RX 1, p. 1)

Petitioner underwent bilateral carpal tunnel releases in 2006 with Dr. Neumeister. (RX 1, p. 1; PX 8)

On July 18, 2006 Petitioner filed an Application for Adjustment of Claim against Respondent alleging an accident date of February 14, 2006 and injuries to her upper extremities (06 WC 30884) (IWCC records).

Beginning on/about December of 2006 Petitioner was working in "Audits" performing keyboarding. She no longer had to lift any buckets. There were case files which would be brought down to her. (RX 1, p. 1)

On/about April 6, 2007 an Arbitrator approved a settlement contract in case #06 WC 30884. Petitioner received 11.25% loss of use of the left arm, 17.5% loss of use of the left hand and 20% loss of use of the right hand. (See IWCC records for case # 06 WC 30884.)

Petitioner saw Dr. Janet Albers on April 14, 2011 with complaints of intermittent elbow pain for the preceding six months. The doctor noted it "hurts to lift anything such as lifting a pan. No change in activity." Petitioner denied any weakness but related medial-sided discomfort. No specific treatment recommendations or diagnosis were noted. (PX 3)

Thereafter,Petitioner filed a Notice of Injury with an accident date of April 14, 2011. In response to the question "What duty were you performing at time of injury?," Petitioner responded "We used the keyboard on the computer and were to get our buckets of work approx.. 40 pounds." As for the location of the injury, Petitioner wrote "at my desk in Individual Processing Division." When asked to detail how the injury occurred, Petitioner wrote "Approx. 15 years ago I was diagnosed with carpal tunnel in both of my hands/wrists. I went for all the testing that was required but my hands were not damaged enough for surgery at that time. My carpal tunnel consistently got worse and in August of 2006 (right hand) and October 2006 (left hand) I had surgery on my wrists to relieve the pain and the numbness. Since then I

have very seldom had problems with my wrists. Approximately in the summer of 2010 my elbows started causing me a lot of pain and have continually gotten worse. I was working in Individual Processing from December of 1999 to December of 2006. Within that period part of our job was to carry 30-40 pds. Tubs to our desk full of batches – this was a constant part of our job. At this time , my wrists were the only thing that bothered me. It wasn't until approximately the summer of 2010 my elbows started causing me problems." (RX 1, p. 2; RX 4; PX 2).

Petitioner returned to see Dr. Albers on May 19, 2011 primarily for a medication follow-up. However, Dr. Albers noted an additional history of bilateral medial epicondylitis and a history of carpal tunnel syndrome for which she had undergone surgery. Petitioner reported several months of progressive elbow pain with trouble moving and leaning on things. For work she has to "lift 30-50 pound buckets – daily had to carry 2-3 buckets and 15 – 20 feet several times daily." Petitioner reported the pain was constant but now was periodic. She has it several times per week but denied any weakness or numbness. Dr. Albers also wrote, "Per Dr. Neumeister's note in 2006 – left decubital tunnel-ulnar nerve subluxation on left on EMG. Concerned about this in light of present symptoms." On examination Petitioner was tender in the medial epicondyles bilaterally. Lab work was ordered for other medical conditions. No specific treatment recommendations were given to the elbows. (PX 3)

On May 27, 2011 Dwight Reese completed a Supervisor's Report of Injury or Illness. (RX 1, p. 2; RX 4)

On June 6, 2011 Dr. Albers completed a CMS Initial Worker's Compensation Medical Report. She noted an accident date of April 14, 2011. Under "History," the doctor noted repetitive activity leading to bilateral medial epicondylitis. Dr. Albers was referring Petitioner to an orthopedic hand specialist. In the interim she had recommended activity modification and non-steroidal anti-inflammatory medication. Regarding restrictions, Dr. Albers recommended decreased repetitive activity. (PX 3)

On June 22, 2011 Respondent filed an Illinois Form 45, First Report of Injury. According to it, Petitioner was experiencing pain in her elbows from past lifting of heavy buckets. (RX 4)

Dr. Albers re-examined Petitioner on July 28, 2011. While Petitioner denied any numbness, weakness or paresthesia, she was tender medially. The doctor prescribed a Velcro elbow splint, ice, and activity modification. She noted, "Workman's comp came through for her arm pain..... First started with lifting heavy buckets at work previously. No longer doing this lifting but notes pain." Petitioner was referred to a plastic surgeon. (PX 3)

On August 10, 2011 Petitioner called Dr. Albers' office reporting that when she had last seen the doctor she had been questioned about tingling in her fingers. According to the note, Petitioner had noticed the day before (8/9/11) that her right hand 4th and 5th fingers were tingling. She was scheduled to see Dr. Neumeister on Monday. She was also told to get the splint as previously ordered. (PX 3)

On August 13, 2011 Petitioner completed a New Outpatient Visit Intake Form prior to her visit with Dr. Neumeister. In response to the question as to her main reason for her visit with the doctor Petitioner indicated that she was having elbow pain in both her right and left elbows for the past year.

She wrote, "In my job several years ago – my work came in buckets weighing [between] 30 – 50 [pounds] which I had to take to my desk – this is when I actually had the carpal tunnel surgery – even though I had had trouble with my wrists going numb – 10 years. "B/F" this particular job. Now for the past year I have had pain in both elbows. (PX 4)

On August 15, 2011, Petitioner was examined by Dr. Neumeister. She reported bilateral medial epicondyle pain and numbness and tingling along the ulnar nerve distribution. Dr. Neumeister noted Petitioner's history of working in a job which required lifting 30 to 50 pound packs of paper from a shelf and taking them to her desk. Petitioner had undergone bilateral carpal tunnel surgeries, and although she had now switched to a different position, she was having new onset of pain in both of her elbows, which had been present for about 1 year. (PX 4) On examination Dr. Neumeister found a positive compression test over the cubital tunnel bilaterally. He felt her examination and symptoms were consistent with bilateral cubital tunnel syndrome and he ordered an EMG. (PX 4)

On August 26, 2011, Petitioner presented to Dr. Trudeau for an EMG/NCV study. In his report Dr. Trudeau noted that Petitioner had previously had bilateral carpal tunnel surgery in 2006 and he had worked with Petitioner at that time. Dr. Trudeau did not record any specific details as to how Petitioner felt she was having a work-related problem. His report did not discuss Petitioner's job duties. He did note, generally, that she was having a "work-related difficulty involving the upper extremities" and that Petitioner had interacted with a workers' compensation coordinator working for Respondent and that was how the date of "4/14/2011 was selected." He further noted that Petitioner had been very descriptive at length in terms of repetitive motion type work activities and lifting and usage and that same was also mentioned in Dr. Neumeister's very detailed report[1]. According to the report, Petitioner was also noticing progressive weakness and difficulty, for example, with fine motor activities such as getting the top off a lid or jar. In particular she noted reduced strength in her right hand. He also noted that Petitioner had "sort of a prediabetes condition" for which she took medication. Dr. Trudeau's studies demonstrated that Petitioner suffered from mild and neurapraxic ulnar lesions, right greater than left in electrodiagnostic testing. Dr. Trudeau also noted that Petitioner did not wish to have surgery at the present but simply wished to get this documented in case there was a progression in the future. (PX 6)

Petitioner returned to see Dr. Albers on September 1, 2011. She reported having seen Dr. Neumeister and being sent for an EMG with Dr. Trudeau. She also reported tingling in her right small finger the week before. Lab work was ordered. Petitioner was noted to be taking Glucophage for prediabetes. (PX 3)

Petitioner returned to see Dr. Neumeister on September 12, 2011, at which time she was complaining of numbness and tingling over the ring and little fingers as well as medial epicondylitis. Her examination remained unchanged since her last visit and they reviewed Dr. Trudeau's studies. Dr. Neumeister and Petitioner discussed surgery which Petitioner did not wish to proceed with at that time. She did, however, agree to a trial of pillow splints. (PX 4)

[1] Not included in PX 6.

On November 3, 2011, Petitioner returned to see Dr. Neumeister reporting significant improvement with the splints although her symptoms were not yet completely resolved. She still complained of elbow pain radiating down to her little fingers with occasional numbness and tingling. However, she did not yet want to proceed with surgery. Petitioner's exam was unchanged. She was to return in a couple of months. (PX 4).

Petitioner returned to see Dr. Neumeister on March 8, 2012 reporting only a slight amount of improvement with the pillow splints. She found her symptoms tolerable for now. On examination she had positive provocative tests at the elbows with the right being slightly worse than the left. Dr. Neumeister wished to see Petitioner back in June to reassess – sooner if her symptoms warranted it. In the interim, she was to continue with the pillow splints and conservative measures. (PX 4)

Petitioner presented to Dr. Albers' office on April 5, 2012 regarding her bariatric surgery, history of breast cancer, hypertension, and anxiety/depression. Petitioner had undergone radiation therapy for her breast cancer and was doing well. Petitioner reported seeing Dr. Neumeister for her cubital tunnel syndrome and wearing splints at night. Surgery was mentioned as a possibility. (PX 3)

On July 9, 2012, Petitioner returned to see Dr. Neumeister. In his office note, the doctor reported he was seeing Petitioner for her ongoing numbness and tingling in the ulnar one and a half digits of both hands which had been worsening over the last couple of months and bothering her to a more significant degree. In addition to a positive provocative compression test, Petitioner had a weakened grip. Petitioner reported her symptoms were getting worse over the previous couple of months and bothering her more significantly. The doctor ordered a nerve conduction study to evaluate the magnitude of her compression. (PX 3, PX 4)

At the request of Respondent, Petitioner was examined by Dr. Williams on October 3, 2012. A written report followed. (RX 1) Petitioner was noted to be right hand dominant. Petitioner and Dr. Williams reviewed her job history with Respondent. At the time of the examination she was working in "Audits" and had been since 2006. Petitioner told the doctor she initially had pain in the left elbow shooting down her arm that was sporadic in nature. At the time of the examination with Dr. Williams her symptoms were bilateral with the right side worse than the left but still sporadic in nature. Petitioner reported the pain as being worse than the numbness and tingling. She denied any nighttime problems and acknowledged using a splint for both elbows, which was helpful. She denied any weakness or dropping of items. She had not undergone any therapy or injections. (RX 1, p. 1)

Petitioner described her job in "Audits" as beginning at 7:45 a.m. and ending at 4:15 p.m. She had one hour for lunch and two fifteen minute breaks. Petitioner was involved in doing keyboarding and would perform research, speak on the phone with taxpayers and assist them in what they needed to do to pay a bill. She answered the phone using a headrest and would use her right hand to pick up the phone and place it on her left shoulder. She also occasionally used a hand stapler with her right hand. She would copy and fax but engaged in no filing. (RX 1, p. 1)

Petitioner advised the doctor she was borderline diabetic but had recently received good blood work results. She also had a history of hypertension and being post-menopausal which was a side effect

of chemotherapy she had undergone in 2011. Petitioner reported she was a social smoker smoking about 2 cigarettes a day which was sporadic and stress-related over the past 36 years. (RX 1, p. 2)

Dr. Williams' report indicates that in approximately December of 2010 Petitioner's elbows began causing her a lot of pain and they had continually worsened. She further stated that while working in IPD from December of 1999 to December of 2006 it was only her wrists that bothered her. Petitioner and the doctor reviewed the position description for a Revenue Tax Specialist II and Petitioner found no significant discrepancies. (RX 1, p. 3)

As part of his report Dr. Williams reviewed medical records form Dr. Trudeau and Dr. Neumeister. (RX 1, pp. 3-4)

Dr. Williams performed a physical examination noting Petitioner's BMI placed her into a significantly obese category which, in turn, would put her at significant risk for peripheral neuropathy. He noted full range of motion of her elbows bilaterally as well as full supination and pronation of the forearms. She had no findings of cubital tunnel syndrome with negative Tinel and negative elbow flexion tests, although she did have positive ulnar nerve subluxation. She had negative Tinel's at the carpal tunnel as well as negative Phalen's and median nerve compression tests. Dr. Williams' impression was that of bilateral elbow ulnar nerve subluxation which would further explain the intermittent nature of her symptoms. He did not believe it was so much due to her work activities but a congenital condition found in 10% to 15% of individuals. Her grip strength testing showed a physiologic bell-shaped curve on both sides with a negative rapid exchange, indicating that she gave a good effort. He did not feel her symptoms were related to her work duties; rather, they were related to her postmenopausal status, her increased BMI, her history of hypertension, and her borderline diabetes. He did not feel that Petitioner's work duties contributed or aggravated to her condition of cubital tunnel syndrome noting that Petitioner reported the buckets she lifted in 2006 were a cause of her problems but the nerve conduction study she underwent in 2006 only showed evidence of carpal tunnel syndrome. Since Petitioner had not lifted the buckets since 2006 and had a negative nerve conduction study for cubital tunnel syndrome at that time he did not feel the mild neuropraxic cubital tunnel she was currently suffering from was "in any way related to that activity, or to any of the other activities that she currently does." (RX 1, pp. 4-5)

On December 20, 2012 Petitioner returned to Dr. Albers' office regarding follow-up for unrelated medical conditions. She also reported some elbow pain for which she was seeing Dr. Neumeister as well as a doctor in Peoria (for workers' compensation) "who confirmed her diagnosis of cubital tunnel syndrome." Dr. Albers wrote, "Symptoms first started 5 years ago when lifting buckets for her job. No longer lifting. Still with intermittent elbow pain – not with activity always." Dr. Albers further noted that Petitioner performed repetitive activity with her job and had six months worsening and shooting down her right arm and hand. She was to follow up with Dr. Neumeister. (PX 3)

On January 31, 2013, Petitioner again returned to Dr. Neumeister's office. Petitioner reported elbow pain radiating down to the ulnar side of her hand that would come and go. Petitioner had stopped lifting anything. Dr. Neumeister further noted, "She uses a keyboard 7 ½ hours a day, 5 days a week. She has no particular hobbies." He also noted that her symptoms would "occasionally increase at work but

not always." On examination Dr. Neumeister noted Petitioner had a positive compression test at the elbow indicative of bilateral cubital tunnel "although it was quite prolonged and I think it is not significant." He felt she might actually have more of a medial epicondylitis as she was very tender around the medial epicondyle and right at the insertion of the flexor origin. Dr. Neumeister recommended a steroid injection to offload some of the medial epicondyle discomfort. Petitioner, however, wished to proceed with anti-inflammatories and the splinting. (PX 4)

On May 17, 2013 Petitioner signed her Application for Adjustment of Claim herein. (AX 2)

Deposition of Dr. Williams

The deposition of Dr. Williams was taken on February 20, 2014. (RX 2) Dr. Williams testified that, based upon his examination of Petitioner in October of 2012, he felt she had bilateral ulnar nerve subluxation which was leading to ulnar nerve neuritis bilaterally. (RX 2, p. 11) This meant that every time Petitioner bent her elbow the ulnar nerve would pop over the medial epicondyle and when the nerve is tender over that area one can occasionally experience symptoms. Dr. Williams did not feel she had any compression of the nerve. Dr. Williams further testified that the condition can be idiopathic, genetic, due to a huge fracture or injury. He testified that it is not due to "simple use." (RX 2, pp. 11 – 14)

Dr. Williams further testified that Petitioner's complaints were not constant. She had them on occasion and at different times. He further explained that Dr. Trudeau's finding of neuropractic cubital tunnel meant it was something transient and not permanent or something occasionally there and then not. (RX 2, p. 16)

Dr. William testified that he reviewed Petitioner's job duties with her. Based upon their discussion he did not feel her job duties caused, contributed, or aggravated her upper extremity conditions. Her job duties, based upon what she told him, varied. She did some keyboarding, some research, talked on the phone, stapled/unstapled, copied and faxed. He further noted that on her Notice of Injury she talked about buckets of work being responsible but she had not performed that job since 2006. Dr. Williams further testified that Petitioner never complained of any repetitive forceful gripping or grasping. He also found it important that Petitioner had other significant medical issues – her diabetes, hypertension, BMI, and post-menopausal status. (RX 2, pp. 16 – 19)

Dr. Williams further testified that other than telling him about her headrest and use of her phone, Petitioner didn't say anything about her workstation and how it was set up. He added:

> [I]f she had spoken about resting her wrists or her elbows or forearms on the table or on her desk because of the way her work setup was set up, which I have seen in other patients' records because they complained to providers of that, obviously, I would have asked her about that, and you can consider that a

significant factor. That was never noted in any of the

treatment records she had with Dr. Neumeister nor with Dr. Trudeau.

(RX 2, p. 21)

Dr. Williams was then asked if resting one's wrist, elbows or forearms, while engaging in one's activities would aggravate Petitioner's condition and he replied "Could, yes, and if she is resting her elbows on the table, while her nerve is subluxed and she is placing extra pressure on that, yeah, I think it definitely could." (RX 2, pp. 21-22) He felt she would need to be doing that activity a third to two-thirds of the day. (RX 2, p. 22)

Dr. Williams also discussed Petitioner's risk factors that could have affected or aggravated her condition, noting they were systemic in nature (RX 2, pp. 22 -23)

Dr. Williams testified that Petitioner's treatment with Dr. Neumeister had been very reasonable. (RX 2, p. 23)

On cross-examination Dr. Williams acknowledged that medical records subsequent to Dr. Trudeau's EMG/NCV study showed Petitioner's symptoms continued to worsen. He did not know that Dr. Neumeister had recently talked about getting a more current EMG. (RX 2, p. 26)

Dr. Williams did not know when Petitioner had been diagnosed with diabetes. (RX 2, pp. 26 – 29) Dr. Williams also agreed that Dr. Neumeister's findings when he saw Petitioner on various dates pretty consistently indicated positive findings for cubital tunnel syndrome. He also agreed that when Dr. Neumeister saw Petitioner in July of 2012 she continued to display positive findings consistent with cubital tunnel syndrome. (RX 2, p. 32)

Dr. Williams acknowledged that he was aware that Petitioner engaged in keyboarding. When asked to assume she did so for six hours a day and with her elbows bent, he agreed that such a posture could certainly either cause or aggravate her ulnar nerve condition. (RX 2, pp. 33-34) While Dr. Williams was unaware of any office notes stating Petitioner rested her elbows or forearms on a table, if he accepted that as true it could be a cause or aggravating factor. (RX 2, p. 35)

On redirect examination Dr. Williams explained that if one had a subluxed nerve it would be painful to place one's elbows on a table or resting. He further added that in Petitioner's instance it was "funny" because she described her pain as "8/10" at rest and only a "1-2" with activity. She also added that it was different all the time. (RX 2, p. 37)

On further cross-examination Dr. Williams explained that ulnar nerve subluxation and medial epicondylitis are two different things although they can go "hand in hand." (RX 2, p. 39)

Additional Medical Treatment

Petitioner returned to see Dr. Albers on April 24, 2014 regarding a check on her medications. She was doing well on her medications for various conditions. No mention of her arms or elbows was made. (PX 3)

On January 6, 2015 Petitioner returned to Dr. Neumeister's office having last been seen in January of 2013. She completed another New Outpatient Visit Intake Form indicating she was there to see the

doctor on account of her elbow pain. When examined by the doctor on January 7, 2015 Petitioner reported bilateral ulnar nerve symptoms with shooting pains throughout the forearm and tingling sensations and intermittent numbness to her small and ring fingers bilaterally. It was noted that Petitioner worked for Respondent and her job didn't involve heavy weight-lifting. Petitioner's physical examination lacked any evidence of current cubital compressive signs. She had no wasting and normal function, flexion and extension of her wrist and digits with no evidence of shooting pains at the moment. She was offered bilateral injections to the cubital tunnels which she agreed to and the doctor ordered a new EMG. (PX 4)

On February 2, 2015, Petitioner was diagnosed, via EMG/NCV, with ulnar neuropathies at both elbows, which were equal on both sides and increased versus those in 2011. (PX 7).

Petitioner followed up with Dr. Neumeister on April 20, 2015 at which point she reported ongoing numbness and tingling in the ulnar distribution worsened by bending of the elbows over long periods of time and pressure over the cubital tunnel. On examination she had positive Tinel's sign and increased numbness and tingling with compression at the cubital tunnel sites bilaterally. Dr. Trudeau's recent nerve conduction studies were summarized as showing moderately severe bilateral cubital tunnel syndrome. Surgery was recommended. (PX 4)

On June 9, 2015, Petitioner underwent a left cubital tunnel release. Dr. Neumeister noted that there was fatty infiltrate of the ulnar nerve with a tight connective tissue wrapping. (PX 4)

Petitioner telephoned Dr. Neumeister's office on June 15, 2015 concerned about a possible infection. She came in later that day and was examined. According to the office note, Petitioner's pre-surgical symptoms had resolved. (PX 4)

On September 15, 2015, Petitioner underwent a right cubital tunnel release and an injection into her left elbow. Pertinent surgical findings included compression of the right ulnar nerve within the cubital tunnel where the nerve was found to be pale and enlarged. A large vein surrounded the nerve and significant fat encircling the nerve was observed. (PX 4; PX 5)

On October 8, 2015 Petitioner returned to see Dr. Neumeister post-surgery on the right side. Dr. Neumeister noted Petitioner was continuing to have evidence of left medial epicondylitis. On examination Petitioner was exquisitely tender to palpation over her medial upper condyle of the left elbow. She was given an injection into the left elbow. (PX 4)

Petitioner followed up with Dr. Neumeister's office on October 16, 2015 reporting significant improvement in her hand numbness, tingling, pain and grip strength. The left elbow injection had significantly reduced her pain and she was pleased with the result. (PX 4)

Petitioner returned to see Dr. Neumeister on January 25, 2016 still reporting issues with the medial epicondylitis. She also reported some medial symptoms on the right side and underwent steroid injections bilaterally. (PX 4)

On April 8, 2016 Dr. Neumeister authored a letter to Petitioner's attorney regarding causal connection. (PX 4) Dr. Neumeister stated that his documentation reported that Petitioner worked on a

keyboard approximately 7 hours per day with her elbows bent and placed on a table in which she was working. "Certainly that position is not ergonomically the most suitable for preventing the ulnar nerve from being entrapped." While he acknowledged not having a complete outline of her activities at work he did reference his January 31, 2013 office note in which he recorded that her symptoms increased at work on occasion. It was the doctor's opinion that if certain activities brought on the discomfort and resolved as she rested then those activities aggravated her condition of cubital tunnel. While there could be many causes of cubital tunnel syndrome, Dr. Neumeister felt that such activity would be an aggravating factor. (PX 4)

Dr. Neumeister's office again examined Petitioner on December 6, 2016. She reported having done very well with her last injections from approximately one year earlier and was there for further injections. She denied any symptoms in her right arm but reported significant left arm pain especially with full extension and it was limiting her normal activities causing significant discomfort. Petitioner's diagnosis was listed as cubital tunnel syndrome and she underwent an injection on the left side. (PX 4)

Deposition of Dr. Neumeister

Dr. Neumeister was deposed on April 17, 2017. (PX 8) Dr. Neumeister is a board certified plastic surgeon with an added certification in hand surgery. Dr. Neumeister testified that he first began treating Petitioner in 2006 but it was for bilateral carpal tunnel syndrome. He began treating Petitioner for her elbows in August of 2011. (PX 8, pp. 1 – 8) At their initial visit in 2011 Petitioner was complaining of her bilateral medial epicondyles (tenderness of the inner aspect of her elbows) and some numbness and tingling in her little fingers and half of her ring fingers which had been ongoing for about one year. Petitioner's examination, according to the doctor, was positive over the cubital tunnel. Dr. Neumeister felt Petitioner had bilateral cubital tunnel syndrome or perhaps compression of the ulnar nerves behind the inner aspect of the elbows. He recommended nerve conduction studies which came back positive for evidence of bilateral ulnar neuropathy. (PX 8, pp. 8 – 13)

Dr. Neumeister further testified that he then saw Petitioner again on September 12, 2011 and her examination was unchanged. He recommended she try pillow splints at night. Dr. Neumeister also testified to subsequent visits with Petitioner which were consistent with the previous examinations. As of July 9, 2012 Petitioner reported slightly worsening symptoms over the preceding few months. Dr. Neumeister did not see Petitioner between January 31, 2013 and January of 2015. When he did see her in January of 2015 he noted Petitioner worked 7 ½ hours a day, five days a week and had no particular hobbies. Dr. Neumeister also testified that Petitioner told him she noticed her symptoms occasionally increased at work where she performed keyboarding. Petitioner still had evidence of bilateral cubital tunnel syndrome, tenderness over the medial epicondyle, numbness and tingling in the small and ring finger, and shooting pain migrating down her forearm. Dr. Neumeister testified that he was unaware of any new trauma or injuries between the visits in 2013 and 2015. Dr. Neumeister testified that he ordered a new EMG/NCV from Dr. Trudeau and they indicated moderately severe bilateral cubital tunnel syndrome which suggested a progression from the earlier study. Thereafter, he performed bilateral cubital tunnel releases on Petitioner and she was given a left elbow injection during the left-sided procedure. Dr. Neumeister testified that Petitioner's ulnar nerves showed some compression around the

leading edge of the muscle belly. Petitioner had some minor infections after both procedures but recovered with antibiotics. (PX 8, pp. 14 – 27)

Dr. Neumeister further testified that when he saw Petitioner on January 25, 2016 he injected both medial epicondyles. Petitioner did not return until December of 2016 when she was examined by one of the doctor's partners. (PX 8, pp. 27 – 30)

Dr. Neumeister was asked to assume that Petitioner did keying at work for between 6 and 7 hours per day and in that process had her elbows bent and on a table. He was also asked to assume that she had no outside activities. Based upon those assumptions Dr. Neumeister was asked whether that work activity or position could or might have either caused or aggravated or accelerated the ulnar nerve issue, cubital tunnel, in her bilateral elbows which necessitated the surgery he performed. Dr. Neumeister responded that if the symptoms Petitioner had or complained about came on while she was performing those activities then he would say the activities or work aggravated her condition. According to the doctor there are many causes and so a number of factors may contribute to the condition or aggravate it and that would certainly be one of them. (PX 8, pp. 31-32) Dr. Neumeister also testified that his opinion would be the same regarding Petitioner's medical epicondyle conditions. (PX 8, p. 32)

On cross-examination Dr. Neumeister testified that he did not have any documentation in his notes that Petitioner suffered from ulnar nerve subluxation which is a condition found in some people where the ulnar nerve flips over the funny bone of the elbow when the arm goes from a straight position to a bent position at the elbow. He did acknowledge testing for it. He also agreed that if one has ulnar nerve subluxation one could be more prone to developing ulnar nerve symptoms. (PX 8, pp. 34-36)

Dr. Neumeister did not recall documenting whether he and Petitioner discussed her smoking history. He acknowledged there are risks associated with smoking, including healing from surgery. Smoking can also have an effect on the nerve because blood supply is to the skin and nerves and nicotine actually decreases blood supply. If Petitioner smoked for 40 years he wouldn't be able to comment on how that might affect anything. If he was performing a big, large surgery with a higher risk of complications, smoking might be a greater concern but with "nerve decompressions, not so much." (PX 8, pp. 37 -41, quote on p. 41)

Dr. Neumeister was asked if Petitioner was employed in the same job throughout the time period he treated her and he responded that he actually didn't have any documentation of whether or not she changed employment. When asked if it was the positioning of her arms that mainly aggravated Petitioner's underlying issues, the doctor testified, "If the symptoms came on while she was in that position or condition, ...then that combination of things aggravated her condition." (PX 8, p. 44) By aggravation, he meant the symptoms started to come on. He added that that would not mean that the physical condition was worsening as a permanent change or causing further degeneration. It was merely producing symptoms. (PX 8, p. 45) Dr. Neumeister could not opine as to whether Petitioner's positional typing was causing a permanent physical change. (PX 8, p. 46)

During his deposition, Dr. Neumeister further stated that he lacked an independent recollection of Petitioner and that he was testifying from his notes. Dr. Neumeister testified that because his notes did

not record whether he discussed Petitioner's job duties with her, he had no knowledge of Petitioner's workspace. (PX 8, p. 46). Dr. Neumeister did not know how much Petitioner typed. Similarly, he did not know how her work day was distributed in terms of work load and breaks. Dr. Neumeister had no specific knowledge of the equipment Petitioner used, such as the type of mouse, keyboard, or other equipment such as wrist or elbow pads. Dr. Neumeister may have felt Petitioner's work place was un-ergonomic, but did not appear to have any specific knowledge as to how or why it was un-ergonomic. Dr. Neumeister did not discuss making changes to Petitioner's workplace. (PX 8, pp. 46 - 50)

Dr. Neumeister further testified that women, menopause, smokers, and people with an elevated BMI are at a higher risk of developing cubital tunnel syndrome. (PX 8, pp. 50 – 53) He felt Petitioner's diabetes was under control but if not controlled, the condition can lead to permanent nerve damage but the nerve symptoms are usually global in nature and not limited to just one nerve. (PX 8, pp. 53-54)

Dr. Neumeister had no opinion as to what caused Petitioner's bilateral cubital tunnel syndrome. (PX 8, p. 55) He also explained that a neuropraxic condition can resolve on its own. He also agreed that a person suffering from ulnar nerve subluxation could have neuropraxic results or be asymptomatic. (PX 8, pp. 55 -56)

On redirect examination Dr. Neumeister re-affirmed that he did not document any evidence of ulnar nerve subluxation in his care of Petitioner. He also testified that because there was intra-operative evidence of compression of both nerves that would tend to contradict that ulnar nerve subluxation was the cause of Petitioner's complaints and symptoms. (PX 8, p. 58) He also acknowledged that if Petitioner had indeed had subluxation he would have recorded it in the office notes but only if it was "flipping right across the elbow." If it was loose or slightly mobile, he probably wouldn't. (PX 8, pp. 59-60)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on August 29, 2017. Petitioner was the sole witness testifying at the hearing. The issues in dispute were accident, causal connection, notice, medical bills, temporary total disability, Respondent's entitlement to a credit for sick days, personal days, or vacation days, and the nature and extent of any injury.

Petitioner testified that she began working for Respondent on September 18, 1978. Since then she has worked for various agencies and/or departments. As of April 14, 2011, Petitioner was working for the Illinois Department of Revenue and, in particular, the "Audit" department. Her job was that of a Revenue Tax Specialist II. She had been there for about ten years and worked from 7:45 a.m. to 4:15 p.m. each day with a one hour lunch and two 15 minute breaks. When not at lunch or on break, Petitioner was "keying." Petitioner testified that in all of her jobs with the State she was either using a computer or a calculator in some respect.

Petitioner testified that in order to engage in "keying" she would sit at her desk and have a screen in front of her along with her keyboard. She would have her elbows on the edge of her desk. Petitioner identified RX 3 as photos of her desk and work area. She identified on the photographs where her elbows would be in relation to the desk/table. There are no arms on her chair.

Petitioner was asked what, if anything, she noticed about her arms and elbows while she was going about her keying activities on April 14, 2011 and she replied that she had been having trouble with pain in her elbows for quite awhile and had been meaning to go to a doctor and finally did so because they were hurting so much. When asked if she associated the pain in any way with her activity at work, she replied, "You know, I didn't really. I did and I didn't." Petitioner explained that she didn't know where it was coming from.

Petitioner testified that she didn't have a computer at home. She denied anything at home that was creating the pain she was experiencing.

Petitioner testified that she initially went to Dr. Albers who referred her to Dr. Neumeister who gave her pillow splints to use. She was also sent to Dr. Trudeau.

Petitioner was asked if she was having problems with her elbows between January of 2013 and January of 2015 when there was a gap in treatment and she replied "I was, but I was just, you know, I just kind of like let it go for a while because I was really not getting anywhere and I just let it go." She acknowledged that Dr. Neumeister discussed surgery in 2013 and when she returned to see him in 2015 her problems were worse.

Petitioner had surgery on both elbows and wasn't off work for very long. She thought it was June 9, 2015 through October 27, 2015. She didn't believe she received any type of workers' compensation benefits while off work. Petitioner also acknowledged undergoing some injections into her arms due to pain which she continued to experience even after her surgeries. Petitioner also testified that she can go days without any pain and then all of a sudden she will feel a sharp achy pain that hurts. She will put her arms down to her side to relieve the pain. Petitioner estimated she does that two to three times a day. Petitioner felt the surgery relieved her numbness in her fingers to a certain extent. She still has some numbness but not as often and it is better since the surgery.

Petitioner testified that when she experienced the pain on April 14, 2011 she went down and got a packet from HR.

Petitioner testified that she no longer mows her lawn. Her hands go numb immediately when she tries to do so. Petitioner testified that she takes Metformin for her pre-diabetic condition. When asked if she smokes, Petitioner replied no and then added "Very rarely." At most she would have a cigarette on the way to work or on the way home. She was trying to quit "at that time" but was smoking in April of 2011. She estimated her smoking habit at two cigarettes per day. Petitioner had gone a year without smoking but then "something traumatic would happen" and she would restart due to stress. It helps her calm down and deal with stress.

On cross-examination Petitioner explained that she has been smoking since she was about 12 or 19 years old or at least for 40 years. When asked if she has always just smoked a couple of cigarettes per day, she replied "probably no." She is currently trying to cut back and had quit for a year but then something would trigger the need for her to begin smoking again. Petitioner estimated that she might have smoked as much as half a pack per day.

Petitioner testified that she couldn't recall exactly what she and Dr. Williams talked about when he examined her. It has been a long time and she was stressed but she did recall he had a beautiful clinic.

Petitioner believed she began working in "Audit" around 2006 or 2007. She did not recall going over the job description (RX 4) with Dr. Williams. When asked if any part of her job requires her to get up and move around, Petitioner responded that she has to get up to go to the fax machine and printer. She also occasionally gets up to visit a little bit or go to the restroom. However, most of the time she is at her desk. Petitioner estimated that she got up to go to the printer four or five times a day. Petitioner also estimated that she wrote between five and ten letters per day and they were usually one page in length. Petitioner also estimated that about half of her day was spent on the telephone. Petitioner also testified that when she was assigned to the telephone she couldn't get any work done, including typing. When answering the phone Petitioner used a shoulder rest.

Petitioner also testified that her chair at work is armless. She acknowledged moving her arms when working and not having them in the same place. She would not put her arms back in the same place all the time. Petitioner acknowledged that she never discussed the position of her elbows while typing with any of her doctors. She did not recall discussing it with Dr. Williams either.

Petitioner testified that in April of 2011 she was tired and having a bad day and finally went to see the doctor. She did not recall what she did between January 31, 2013 and January 7, 2015 but did recall going back to the doctor when it became more painful. She did not have any change in her job duties at any time. She wasn't sure if she smoked during that time.

Petitioner acknowledged that she could not state exactly when she stopped mowing her lawn but recalled doing so when it became too painful. She did not recall if she discussed the pain she was having while mowing with any of the doctors.

On redirect examination Petitioner reiterated that she typed 6 to 8 hours per day. Petitioner was also asked about the amount of time she spent on the phone in April of 2011. When asked if she spent as much time on the phone as she discussed on cross-examination, she replied that things change and when she was under the supervision of Dwight Reese everybody was on the phone and working at the same time. She had the shoulder cradle at that time and would be keying while on the phone. While working for Dwight Reese everybody had a quota of 150 accounts per month. She also did the copying and faxing during that time and estimated spending 10 to 15 minutes a day doing that. Petitioner estimated she spent seven hours a day keying.

On further cross-examination Petitioner was asked about the time period when they began bifurcating the phone activities. She believed it began under Mr. Reese but when he left "Danny" continued it. She acknowledged that when answering the phones, the phone calls would interrupt her typing. However, she would type while speaking with the person on the phone. Petitioner further described how she went about answering phones and working the computer prior to the bifurcation change on phone assignments.

During the arbitration hearing photographs were taken of Petitioner's posture while typing/keying. Those photographs were sent to the Arbitrator by agreement of the attorneys and have been included in the record as Respondent's Group Exhibit 5.

The Arbitrator concludes:

Issues (C) Accident, (D) Date of Accident, and (F) Causal Connection.

Petitioner failed to prove she sustained an accident on April 14, 2011 that arose out of and in the course of her employment with Respondent or that her conditions of ill-being in her elbows were causally related to her employment duties with Respondent.

In a repetitive trauma claim, the claimant bears the burden of showing, by a preponderance of the evidence, that she suffered a disabling injury arising out of and in the course of her employment. The "arising out of" component is focused on causal connection as it must be shown that the injury had its origin in some risk connected with, or incident to, the employment. The unique facts of each case must be closely analyzed and scrutinized.

At the outset the Arbitrator notes that there are some troubling aspects to this case. First, there is the fact that Dr. Albers' office note of April 14, 2011 notes a prior visit with Dr. Neumeister in 2006 and a reference to cubital tunnel syndrome. Second, there is Petitioner's settlement of case # 06 WC 30884 wherein she received a settlement of 11.25 % loss of use of the left arm. Third, Dr. Neumeister's and Dr. Trudeau's records from 2006 are missing from the record. Fourth, Petitioner, for a significant period of time, associated the onset of her symptoms with the lifting of buckets of work that she was doing prior to her transfer to "Audit." None of the foregoing was discussed or addressed during the arbitration hearing.

When Petitioner presented to Dr. Albers in April of 2011 she did not associate her symptoms with any work activities. Her elbow complaints were "intermittent" and Petitioner reported it hurt to "lift anything" such as a pan. This was very different than the picture Petitioner painted at the arbitration hearing. At trial Petitioner was uncertain if she even associated her symptoms with work in April of 2011. While she testified that her arms were "tired" on April 14, 2011 and she finally needed to have them checked out, she did not provide that history to Dr. Albers. References to Dr. Neumeister's treatment in 2006, coupled with the settlement terms from the 2006 case, create a reasonable inference in the Arbitrator's mind that Petitioner was having elbow complaints (at least in the left arm) for some time prior to April 14, 2011. When Petitioner returned to see Dr. Albers in May of 2011 she referenced "lifting" 30 to 50 pound buckets of work and having to "carry" them several feet several times daily. Petitioner next completed an Injury Report and again identified the onset of her complaints with the work activity of lifting buckets. She acknowledged having switched jobs but said nothing about any correlation between her typing position and/or amount of typing and her elbow symptoms.

Petitioner then began treating with Dr. Neumeister and, again, only referenced the activity of lifting and carrying buckets of work. There was no mention of her typing position and/or amount of typing as being associated with her symptoms. Dr. Trudeau's 2011 report was unusually vague in its discussion of Petitioner's job duties and complaints. Dr. Williams noted in his report that Petitioner felt the lifting of

buckets in 2006 was the cause of her elbow complaints. She did not mention any problems with typing or the position of her arms while typing when seen by the doctor.

Until January 31, 2013 Petitioner consistently associated the onset of her problems with the lifting and carrying of heavy buckets. The first mention of any association between typing and Petitioner's elbow complaints surfaced in Dr. Neumeister's January 31, 2013 office note wherein he noted that Petitioner used a keyboard 7.5 hours a day and five days a week. She denied any hobbies. However, he also noted at that time that Petitioner's symptoms would occasionally increase at work but not always. Again, she did not mention of the position of her elbows as being a problem. While Dr. Neumeister would go on to testify that he felt Petitioner's work activities aggravated her bilateral elbow conditions he based that opinion on Petitioner's experiencing symptoms while engaged in that activity. He further testified that the symptoms were just that and were not creating any permanent damage to Petitioner's nerves. He acknowledged knowing very little about Petitioner's job and the specifics of her work station and duties.

The medical records and accident reports indicate that Petitioner's symptoms were brought on by lifting. She mentioned the lifting and carrying of buckets at work as well as lifting of jars. Dr. Neumeister did not render a causation opinion based upon a consideration of that activity. None of Petitioner's medical records clearly indicate that Petitioner's elbow complaints began with her job duties in "Audit;" rather, they were consistently associated with the job where she had buckets of work assigned to her. While Petitioner later mentioned to the doctor that she also noticed symptoms while typing, this wasn't always the case as she acknowledged the symptoms were intermittent in nature. She also testified that she had to stop mowing her lawn with her push mower because it was too painful. This information was not mentioned to any doctors either. Additionally, despite surgery, Petitioner has continued to have some symptoms in her elbows albeit not as extensive as what she noticed before the surgery. Illinois has not adopted the positional risk doctrine and, therefore, it is not enough that an employee may notice symptoms while working. Dr. Neumeister noted no permanent damage to her nerves as a result of her experiencing intermittent symptoms at work.

Dr. Williams' opinions, in contrast to those of Dr. Neumeister, were based upon a more thorough discussion and understanding of Petitioner's job duties for Respondent. While Petitioner could not recall if she talked in depth with Dr. Williams regarding her job and symptoms, she did not deny anything contained in his report. Dr. Williams opined there was no causation and no aggravation. His opinions were based upon a review of Petitioner's treating records and an understanding of what she actually did at work. While Dr. Williams agreed that keyboarding all day (or a substantial part of one's day) with her elbows bent and in a static position on the desk could cause or aggravate an ulnar nerve condition Petitioner did not rest her elbows or her forearms on the table. She testified, on cross-examination, that she moved her arms when working and would not always have them in the same place. She did not always have them resting on the desk or table. Dr. Williams correctly noted she never discussed the position of her arms or elbows while typing with any doctor. Indeed it appears that the first discussion of the position of Petitioner's arms and its possible causative relationship to elbow conditions came out during Dr. Williams deposition in 2014. The Arbitrator does not feel that the doctor's general testimony regarding the possibility of causation under those circumstances should be binding in light of his correct assessment that Petitioner had never alleged as much to him or any other doctor. If further appears to this Arbitrator

that Petitioner's testimony regarding the positioning/placement of her elbows while typing was done in an attempt to dovetail into Dr. Williams' testimony. There is no corroboration in the medical records for her testimony regarding the mechanism of injury.

Looking further at Petitioner's testimony, Petitioner did not provide evidence that demonstrated her ulnar nerves were always subluxed while at her desk. In fact, the evidence suggests otherwise as Petitioner sometimes had symptoms while typing and sometimes did not. Her testimony about whether she associated her symptoms with work was uncertain. Petitioner provided contradictory statements to each physician regarding her symptomology while at rest and at work. While contradictory, this does not mean that Petitioner's statements were untrue, but rather indicative of transient symptomology which could not be directly tied to typing or the position of her elbows when typing. In the end, and based upon the evidence in the record, the Arbitrator is unable to conclude that Petitioner sustained a repetitive trauma injury to her elbows that arose out of and in the course of her employment with Respondent or that her bilateral elbow conditions were causally connected to her employment duties for Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

Issue (E) Timely notice.

Issue (J) Medical Services/Bills.

Issue (K) Temporary Total Disability Benefits.

Issue(L) Nature and Extent of in the Injury.

Issue (N) Is Respondent due a credit?

Based upon the Arbitrator's determination on accident and causal connection, the remaining issues are rendered moot. Petitioner's claim is denied and no benefits are awarded.

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STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tiffany Molton,

Petitioner,

vs.

NO: 15 WC 42442
16 WC 11409

Red Bud Regional Care,

Respondent.

18IWCC0381

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's Decision - finding Petitioner failed to prove a causal relationship exists between the accidental injuries she sustained on March 31, 2016 and her condition of ill-being as it relates to her right shoulder. Based on this finding, the Commission vacates the Arbitrator's award of medical expenses related to treatment of the right shoulder, including right rotator cuff surgery, and the award of prospective medical care consisting of physical therapy. "[T]he Commission is not bound by the arbitrator's findings and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. [citation omitted]." *R.A. Cullinan and Sons v. The Industrial*

Commission, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240 (1991). The "interpretation of the testimony of medical witnesses is particularly within the province of the Industrial Commission. [citation omitted]." *A.O. Smith Corporation v. The Industrial Commission*, 51 Ill. 2d 533, 537, 283 N.E.2d 875 (1972).

Findings of Fact

At the June 9, 2017 hearing, Petitioner testified on March 31, 2016 she was working light duty at Respondent. T. 31. Petitioner testified, "I was doing paperwork in our little chart room by the nurse's station, and our doctor for the facility came in to see her patients and needed the chart, so I stood up and moved back. And while she was talking to me about the patients and looking at the charts, the three wooden shelves that were up on the wall behind me full of the manuals and CNA charting books and stuff collapsed down off the wall onto my neck, right shoulder, and my back." T. 32. Petitioner testified she was hit in the back of her neck, the right side of her neck, in the right shoulder and down her back and right arm. *Id.* Petitioner testified she felt immediate pain in her neck, right shoulder and her back. T. 33.

On cross-examination, Petitioner testified the bookshelves fell onto her right shoulder, the right side of her neck and down her back towards the end of her right shoulder blade. T. 55. Petitioner described being initially hit at the top of her right shoulder towards her neck, and as the shelving/books continued to fall, she was struck in the shoulder blade and down her back. T. 55-56. On re-direct examination, Petitioner testified the shelves struck the top and back of her right shoulder and the back of her neck, and then the books fell striking her low back. T. 75.

The medical records evidence Petitioner was evaluated on March 31, 2016 at the emergency room at Red Bud Regional Hospital. The following history was noted: "The problem was sustained (when) a large shelf fell on her from the wall." "34 y.o. female was at work at the care center when a large shelf on the wall (with books, charts) fell on her. It struck the right side of her neck, shoulder and back and she is c/o pain in those regions. States right arm is numb." It was noted the symptoms were located in the thoracic and lumbar area. On cervical examination, there was mild tenderness at C5, C6 and C7 and range of motion was painful. On thoracic and lumbar examination, there was moderate pain, low back spasm and mid back spasm. On right shoulder examination, there was mild pain over the right proximal clavicle, no swelling and mild numbness in the right arm. A cervical CT scan was performed which was unremarkable; impression was no acute traumatic abnormalities of the cervical spine. Thoracic spine x-rays impression was no acute osseous abnormalities. Lumbar spine x-rays impression was no acute osseous abnormalities. Right shoulder x-rays impression was no acute osseous abnormalities. The emergency room physician reviewed the x-rays and CT scan. His impression was back contusion, right shoulder contusion and myofascial cervical strain. Petitioner was prescribed medication, taken off work for the following day and return to work the next Monday. Petitioner was discharged with a cervical collar and to follow-up with her primary care physician. PX9.

Petitioner testified she saw Dr. Gornet on April 5, 2016. Petitioner had been seeing Dr. Gornet for a low back injury she sustained on December 1, 2015. Petitioner testified she told Dr. Gornet about the March 31, 2016 accident and her complaints. T. 35. Dr. Gornet ordered a cervical MRI, which Petitioner underwent at MRI Partners of Chesterfield. *Id.* Dr. Gornet also recommended epidural steroid injections for Petitioner's neck, which she underwent with Dr. Blake, but the injections did not help. T. 37. Petitioner continued to treat with Dr. Gornet, who continued physical therapy, prescribed medications, and continued to place work restrictions. *Id.* Dr. Gornet then referred her to Dr. Mall for her right shoulder complaints. T. 38.

The medical records evidence Petitioner saw Dr. Gornet on April 5, 2016. The following history was noted: "We have been treating her for her low back. She has been on sedentary duty. She states that she was in her normal course of health until 3/31/16. She was working in the office. She backed up and some brackets on the shelves gave way causing three shelves to suddenly fall on her, striking her on her neck and upper back to the right side and right shoulder. This incident was reported." Dr. Gornet noted Petitioner treated at the ER and was released. Petitioner reported she felt this aggravated her underlying condition in her low back. Petitioner complained of a new onset of neck pain into the right shoulder and right arm with numbness and weakness and right scapular pain. Petitioner did not recall any previous problems of significance with her neck. PX8.

Petitioner testified she sought treatment from Dr. Mall on May 10, 2016 and advised him regarding the March 31, 2016 work accident and right shoulder complaints. T. 38. Dr. Mall ordered a right shoulder MRI, which Petitioner underwent at MRI Partners of Chesterfield. *Id.* Dr. Mall ordered physical therapy for Petitioner's right shoulder and placed additional work restrictions regarding her right shoulder. T. 39. Respondent did not accommodate those restrictions. *Id.* Petitioner testified her right shoulder condition did not improve with conservative treatment. *Id.* On September 8, 2016, Dr. Mall performed right shoulder surgery. *Id.* Dr. Mall authorized Petitioner off work following that surgery and ordered additional physical therapy at Apex, which she attended. *Id.*

The medical records evidence Dr. Mall evaluated Petitioner on May 10, 2016. The following history was noted: "She was working in the office area. However, when doing so, three shelves came down and crashed onto the top of her right shoulder. This caused immediate pain and symptoms with regard to her right shoulder and cervical spine...This injury occurred on March 31, 2016." On examination of the right shoulder, Dr. Mall found pain to palpation over the AC joint and over the distal clavicle; pain with rotator cuff strength testing and some weakness with rotator cuff testing with 4+/5 strength in the right supraspinatus distribution, 5-/5 in the infraspinatus distribution and 5-/5 in the subscapularis distribution in the right shoulder, compared with 5/5 strength in the left shoulder; intact sensation and motor function bilaterally. On examination of the neck, Dr. Mall found some point tenderness along the cervical spine and some pain with range of motion. Dr. Mall reviewed right shoulder x-rays and noted they did not demonstrate any fracture or dislocation. Dr. Mall's assessment was right shoulder

contusion with AC joint injury. Dr. Mall recommended an AC joint injection, which was given at this visit, prescribed medications and physical therapy. Dr. Mall opined, "In terms of causation, I do believe that she suffered a right shoulder injury and potentially a cervical spine injury when these shelves collapsed down onto her right shoulder. A direct impact like this to the shoulder can cause AC joint injuries most definitely but also can cause potentially a superior labral injury. AC joint injuries typically are caused by a fall onto the point of the shoulder, which is basically the same injury mechanism that the patient describes." Dr. Mall ordered a right shoulder MRI. PX13.

On June 3, 2016, Petitioner underwent a right shoulder MRI post arthrogram. The radiologist's impression was: 1) high grade partial thickness interstitial tearing of the distal and anterior insertional fibers of the supraspinatus tendon without a full thickness tendon tear though given the severity of partial thickness tear, this could represent a functional full thickness tear; there was no atrophy of the supraspinatus muscle body; 2) bicipital tendinosis with partial thickness interstitial tearing within the rotator interval without a full thickness tear or tendon retraction; 3) small amount of fluid within the subacromial/subdeltoid bursa suggesting mild bursitis. PX10.

On June 3, 2016, Dr. Mall re-evaluated Petitioner who reported physical therapy had made her right shoulder pain worse. Dr. Mall reviewed the right shoulder MRI post arthrogram and diagnosed a right shoulder rotator cuff tear and AC joint sprain with biceps tendonitis. Dr. Mall recommended arthroscopy and rotator cuff repair. Dr. Mall opined, "The patient is very young at 34 years of age. Therefore, it would be extremely unlikely, if at all possible, for her to have a rotator cuff tear that was preexisting. Therefore, I do believe this work injury caused the rotator cuff tear." Dr. Mall noted this would require surgical intervention and Petitioner wished to proceed. Dr. Mall provided Petitioner the same work restrictions. PX13.

On July 5, 2016, Dr. Blake of Pain & Rehabilitation Specialists administered Petitioner an epidural steroid injection at C5-C6. PX11. Petitioner saw Dr. Mall on July 12, 2016 and reported she continued to have right shoulder pain and it seemed to be getting worse. Dr. Mall's examination and assessment were the same and he noted he was awaiting surgical approval. Dr. Mall imposed the same work restrictions. PX13. On July 19, 2016, Dr. Blake administered Petitioner an epidural steroid injection at C4-C5. PX11.

In a Genex Utilization Review Report dated July 29, 2016, it was noted Petitioner was denied certification for requested right shoulder surgery as there was no mention of any previous conservative treatments, and no MRI report was submitted for review. PX16.

On August 23, 2016, Petitioner reported to Dr. Mall her right shoulder pain was getting worse. Petitioner informed Dr. Mall she had received a letter from Respondent's workers' compensation insurer denying authorization for surgery. Dr. Mall noted he was somewhat unsure what the concerns were regarding the care and management of Petitioner. Dr. Mall noted

Petitioner was not at an age in which degenerative rotator cuff tears would be seen. Dr. Mall opined surgery was warranted after failure of conservative treatment. Dr. Mall noted that in the Genex UR report, there was no mention of any previous conservative treatment and there was no official MRI report provided for review. Dr. Mall opined Petitioner had met ODG guidelines for surgery. PX13.

In a Genex Utilization Review Report dated August 30, 2016, it was noted that appeal of the former decision was granted. It was noted based on review of submitted records, the prior non-certification appeared to have been inappropriate. It was noted Petitioner had failed conservative care of physical therapy, prescribed medications and injections and she had met ODG guidelines for surgery. PX17.

Petitioner underwent surgery at Orthopedic Ambulatory Surgery Center of Chesterfield on September 8, 2016. In his operative report, Dr. Mall noted pre-operative diagnoses of 1) right shoulder rotator cuff tear and biceps tendonitis; 2) AC joint inflammation. Dr. Mall performed the following procedures: 1) arthroscopic rotator cuff repair of the supraspinatus from a subacromial approach; 2) arthroscopic rotator cuff repair of the subscapularis from an intraarticular approach; 3) subacromial decompression and acromioplasty; 4) subcoracoid decompression and coracoplasty; 5) arthroscopic AC joint resection; 6) biceps tenotomy. PX12. In a Work Status Report that same day, Dr. Mall authorized Petitioner off work. PX13.

On September 27, 2016, Petitioner reported to Dr. Mall she was doing well and making progress in terms of her pain. Dr. Mall assessed status post rotator cuff repair and continued physical therapy and use of a sling. In his Work Status Report, Dr. Mall noted Petitioner may return to work light duty with no use of the right upper extremity. Petitioner reported to Dr. Mall on October 25, 2016 she was making progress in physical therapy. On examination, Dr. Mall noted about 150 degrees of forward elevation and external rotation to the side of about 30 degrees. Petitioner was to continue physical therapy and ween off the sling in a week. On November 22, 2016, Petitioner reported she was making good progress in physical therapy. On examination, Dr. Mall noted about 100 degrees of forward elevation and external rotation to the side of about 15 degrees. Petitioner was to continue physical therapy with the same work restrictions. PX13.

On December 27, 2016, Dr. Mall re-evaluated Petitioner who reported improved range of motion with physical therapy. On examination, Dr. Mall found good strength with external rotation; good range of motion with forward elevation and external rotation; some weakness with rotator cuff strength testing in the supraspinatus distribution. Dr. Mall continued physical therapy and noted Petitioner was on target with her recovery. On January 31, 2017, Petitioner reported some weakness. On examination, Dr. Mall noted good strength with external rotation strength testing and poor strength with supraspinatus strength testing at 4/5. Petitioner was to continue physical therapy. PX13.

On February 27, 2017, Dr. Nogalski evaluated Petitioner pursuant to §12 of the Act at Respondent's request. In his report of that date, RX2, Dr. Nogalski noted Petitioner was seen for her right shoulder relative to a claimed injury on March 31, 2016. Dr. Nogalski noted Petitioner's job with Respondent. Dr. Nogalski noted the December 1, 2015 accident, low back injury and treatment. Dr. Nogalski noted Dr. Gornet had released Petitioner to light duty on March 25, 2016 and she returned to work in that capacity. Dr. Nogalski noted the March 31, 2016 accident; all three shelves, books and charts came down on Petitioner's right neck, right shoulder, back and shoulder blade area. Dr. Nogalski noted Petitioner's treatment with Dr. Gornet and Dr. Mall. Petitioner reported that compared to before the right shoulder surgery, she still had a lot of pain. Petitioner noted many of the same symptoms that she had before the surgery. Dr. Nogalski noted, "She does not really believe surgery has helped significantly." Dr. Nogalski noted Petitioner was currently not working as her restrictions were not accommodated. Dr. Nogalski noted, "She denies any previous problems with the shoulder." Petitioner reported she had pain in the top and front of the right shoulder; difficulty using her right arm to shift car from park to drive and difficulty fastening her bra or reaching around her back. She complained of pain in the neck on both sides of the cervical spine. She had pain that went from the neck down into the back of the shoulder. She had difficulty moving her neck and shoulder together. She had problems when she tried to reach out away from her body as well as hold things out away from her in general. She had right arm weakness and tingling sensations from her neck down into the arm and occasionally to the thumb, index and middle finger. Petitioner denied any previous neck or shoulder problems. Dr. Nogalski reviewed and noted the medical records. Dr. Nogalski's impression was: 1) right neck/posterior superior shoulder contusion from March 31, 2016; 2) history of pre-existing bilateral shoulder problems as documented on March 21, 2016 prior to the claimed March 31, 2016 injury.

Dr. Nogalski opined, "With respect to the right shoulder, I do not believe that Ms. Molton's right shoulder complaints are the direct and proximate result of the 3/31/16 claimed work injury." Dr. Nogalski noted there were no AC joint findings on June 3, 2016 MRI. Dr. Nogalski opined, "Mechanism of injury as described by Ms. Molton, as well as in the records provided by providers that Ms. Molton saw prior to Dr. Mall, documented a direct blow injury to the back of the shoulder and neck region. This mechanism of injury would not cause a rotator cuff tear. In fact, the area where she was struck by the shelves would fall upon the bony arch of the shoulder which would be above and protective of the rotator cuff. The soft tissues and bone above this would protect the rotator cuff itself. She has not had any torque or twist to the shoulder and does not describe this in the 3/31/16 event. As described by Dr. Gornet, Ms. Molton had had previous shoulder issues on both sides prior to 3/21/16, and it is more likely than not that these issues pre-existed her claimed 3/31/16 activities." Dr. Nogalski further opined, "She sustained a direct blow injury to the upper shoulder by her neck and posterior scapular region. She did not sustain an injury to the rotator cuff region of the shoulder and her complaints of neck and shoulder pain appear to have been morphed into a rotator cuff issue. I strongly believe that her rotator cuff findings pre-existed the claimed 3/31/16 event. I do not find a clear link in logic with Dr. Mall's assertion that her rotator cuff findings would have to come from, or

be aggravated by, the 3/31/16 event, when in fact she had had, and admitted to, previous shoulder issues. Most importantly, she also did not have a mechanism of injury on 3/31/16 that would reasonably cause or aggravate a rotator cuff condition." Dr. Nogalski believed Petitioner's symptoms were predominantly neck related and myofascial. Dr. Nogalski noted she had some shoulder tightness on examination which may be due to a capsulitis within the shoulder. Dr. Nogalski noted this appeared to have developed after the surgical procedure and would relate more to the surgery than to a specific injury or precipitating factor for this process prior to surgery. Dr. Nogalski noted some shoulder girdle rehabilitation due to the direct blow injury would be reasonably appropriate. Dr. Nogalski opined the surgery for her shoulder condition would not be causally related to the claimed March 31, 2016 event. Dr. Nogalski noted Petitioner was limited in her lifting capabilities and recommended no lifting more than 10 pounds and no use of the right arm over the shoulder level. Dr. Nogalski opined Petitioner was at maximum medical improvement for her right shoulder. RX2.

On February 28, 2017, Petitioner reported to Dr. Mall physical therapy had not been approved. Dr. Mall noted she had undergone an independent medical evaluation the day before. On examination, Dr. Mall found some mild crepitus with range of motion; good rotator cuff strength in the infraspinatus distribution; significant weakness in the supraspinatus distribution with 4/5 strength. Petitioner was to continue physical therapy and the same work restrictions. Dr. Mall ordered a right shoulder MRI. On March 28, 2017, Dr. Mall noted Petitioner reported there was still no physical therapy approval. Petitioner was provided some home exercises. PX13.

During his May 1, 2017 deposition, PX14, Dr. Mall testified he is a board certified orthopedic surgeon. Dr. Mall recited his medical records, noted above. Dr. Gornet was treating Petitioner's cervical spine and Dr. Mall was not. PX14, p. 13. Dr. Mall opined a causal relationship exists between Petitioner's right shoulder condition and the March 31, 2016 accident. PX14, p. 18-19. During surgery, Dr. Mall noted there was blood found in the tendon, an indication of a traumatic rotator cuff tear. PX14, p. 25-26. Physical therapy was not authorized after Dr. Nogalski's February 28, 2017 report. PX14, p. 30. Dr. Mall disagreed with Dr. Nogalski that Petitioner's torn rotator cuff was degenerative in nature. PX14, p. 31. Dr. Mall opined his treatment was reasonable, necessary and causally connected to the March 31, 2016 accident. PX14, p. 33. Dr. Mall opined the physical therapy he recommended was causally related to the March 31, 2016 accident. PX14, p. 34.

On cross-examination, Dr. Mall testified Petitioner gave a history of a wooden shelf with binders and charts coming off a wall and striking her on the top and back of her right shoulder, the scapular area. PX14, p. 36. Dr. Mall opined that is not the classic accident for a rotator cuff tear. PX14, p. 36. Dr. Mall did not have the ER records to review. PX14, p. 37. The x-rays taken in Dr. Mall's office looked normal. PX14, p. 38. Dr. Mall reviewed the MRI arthrogram. PX14, p. 39. Petitioner provided Dr. Mall a history of previous shoulder problems, but Dr. Mall did not know whether this was for the right or left shoulder and he interpreted this as one

shoulder. PX14, p. 44. Dr. Mall did not diagnose impingement syndrome. PX14, p. 45. Dr. Mall opined mature individuals can get tears in the supraspinatus or subscapularis tendons without any work-related trauma. PX14, p. 47. Dr. Mall opined it is very unlikely Petitioner could have the same findings noted in the operative report absent any trauma because of her age; less than 1%. PX14, p. 48. The risk of a full thickness tear in someone less than age 50 is around 4%. PX14, p. 49.

On May 9, 2017, Dr. Mall noted Petitioner complained of some pain in the superior aspect of her right shoulder. On examination, Dr. Mall found the same weakness. Dr. Mall recommended continued physical therapy. Dr. Mall noted, "I do not really have any additional treatment to offer her for her right shoulder until she gets some physical therapy and gets this approved." Dr. Mall opined lack of physical therapy is likely the reason why Petitioner has the pain she is describing. PX13.

During his May 22, 2017 deposition, RX1, Dr. Nogalski testified he is a board certified orthopedic surgeon. Dr. Nogalski recited from his February 27, 2017 report, which is noted above. Dr. Nogalski testified the findings noted in the right shoulder MRI would be in the front of the shoulder. RX1, p. 13. Dr. Nogalski testified the supraspinatus tendon is located in the front of the shoulder, just to the front and outside of the shoulder, and the subscapularis tendon is directly in front of the shoulder. RX1, p. 15. Dr. Nogalski opined no causal relationship exists between Petitioner's right shoulder condition of ill-being and the March 31, 2016 accident. RX1, p. 17. Dr. Nogalski opined the mechanism of injury was to the back of the shoulder and the neck region. RX1, p. 17. Dr. Nogalski noted the main pathology treated and addressed by Dr. Mall were tears of tissue that were in front of the right shoulder that could not reasonably have been caused by the event that was described by Petitioner. RX1, p. 18. Dr. Nogalski opined there did not appear to be any correlating findings on the right shoulder MRI from a direct blow injury that would reasonably be attributable to any rotator cuff problems. RX1, p. 18. Dr. Nogalski believed Petitioner had preexisting rotator cuff issues as evidenced by Dr. Gornet's March 21, 2016 record. RX1, p. 19. Dr. Nogalski opined no causal connection exists for Dr. Mall's treatment and surgery. RX1, p. 19. Dr. Nogalski opined Petitioner can work her regular duty job as a result of any injury she suffered on March 31, 2016. RX1, p. 20. Dr. Nogalski opined restrictions would most reasonably be related to some cervical issue. RX1, p. 20. Dr. Nogalski opined Petitioner had reached maximum medical improvement for her right shoulder contusion injury. RX1, p. 20-21.

On cross-examination, Dr. Nogalski testified he did not review any MRI films. RX1, p. 23. During his examination, Petitioner exhibited no signs of malingering or symptom magnification. RX1, p. 24. Dr. Nogalski opined a post arthrogram MRI is more valuable in diagnosing interarticular injuries to the shoulder than plain MRI. RX1, p. 24. Dr. Nogalski acknowledged the best way to confirm or rule out a rotator cuff tear would be to look at the rotator cuff arthroscopically or in open procedure. RX1, p. 25. Dr. Nogalski did not review the actual films of the June 3, 2016 post arthrogram MRI. RX1, p. 29. Dr. Nogalski had no reason

to dispute what Dr. Mall recorded in his operative report. RX1, p. 31. Dr. Nogalski agreed with Dr. Gornet's decision to defer any further treatment of Petitioner's cervical spine until she completed her shoulder treatment. RX1, p. 31. Dr. Nogalski acknowledged Petitioner told him she had not experienced any right shoulder problems prior to March 31, 2016, but stated the records contradict Petitioner's statement to him. RX1, p. 32. Besides Dr. Gornet's March 21, 2016 record, the findings described by Dr. Mall are relatively old type findings that are reasonably present in patients that have rotator cuff tendinopathy. RX1, p. 33. Dr. Nogalski had not seen any other treatment records that document complaints of right shoulder pain by Petitioner prior to March 31, 2016. RX1, p. 33-34. Dr. Nogalski opined it is possible Petitioner may require additional treatment for her right shoulder in the form of physical therapy, but not a repeat right shoulder MRI. RX1, p. 35.

Dr. Nogalski testified there is some overlap between shoulder injuries and cervical spine conditions. RX1, p. 36. At the February 27, 2017 §12 evaluation, Petitioner had complained of pain in her neck on both sides and Dr. Nogalski opined it is possible that complaint would be related to a neck injury she sustained on March 31, 2016. RX1, p. 37. Dr. Nogalski would defer to Dr. Gornet regarding the appropriate treatment for Petitioner's cervical condition. RX1, p. 37. Dr. Nogalski testified pain from the neck down to the back of the shoulder can be a complaint related to a cervical spine injury and the same was true for tingling from the neck down the arm. RX1, p. 37. Dr. Nogalski opined these complaints could be related to a cervical spine injury Petitioner sustained on March 31, 2016. RX1, p. 38. Dr. Nogalski opined it was impossible for Petitioner to have sustained a rotator cuff tear by the mechanism she described. RX1, p. 39-40. Dr. Nogalski opined the likelihood of somebody Petitioner's age having a rotator cuff tear without substantial injury is 10% to 20%; that is the probability of degenerative rotator cuff tear for a woman Petitioner's age. RX1, p. 40. Dr. Nogalski acknowledged the March 20, 2016 pain diagram for Dr. Gornet had no reference to the right shoulder or radiculopathy. Petitioner's attorney read Dr. Gornet's March 21, 2016 record. RX1, p. 44. On March 21, 2016, Dr. Gornet noted, "She does admit to a history of shoulder problems, which she also feels was worse after the (December 1, 2015) accident." PX8. Dr. Nogalski read the above note. RX1, p. 44. Dr. Nogalski stated the language in the note is ambiguous; "Shoulder; shoulders." RX1, p. 45. Dr. Nogalski acknowledged Dr. Gornet did not record any findings regarding the right shoulder, but he did regarding the left shoulder. RX1, p. 45-46.

Conclusions of Law

The Commission finds Petitioner failed to prove a causal relationship exists between the accidental injuries she sustained on March 31, 2016 and her condition of ill-being as it relates to her right shoulder. The Commission finds Dr. Nogalski's opinions more persuasive than those of Dr. Mall. Dr. Nogalski testified regarding the mechanism of injury of the March 31, 2016 accident; the torn rotator cuff tendons are located in the front of the shoulder, and Petitioner was hit in the back of the right shoulder. Petitioner did not testify to nor do the medical records memorialize her hitting the front part of her right shoulder. Dr. Nogalski persuasively testified

that the mechanism of injury as described by and testified to by Petitioner was not a competent cause or aggravating factor for Petitioner's right shoulder condition. Further, Dr. Nogalski opinioned such condition was degenerative in nature.

In contrast, Dr. Mall felt the mechanism of injury, though not typical to cause a rotator cuff injury was plausible. Dr. Mall's causation opinion is based upon speculation and supposition, and therefore, the Commission affords it little weight. Specifically, Dr. Mall testified: "And so my thought process is that maybe she was trying to reach up to stop it from falling on her, or if she got hit just the right way…" PX14, p. 20. Such assumptions are not borne out by the evidence. Petitioner was struck from behind. There is no evidence she was aware of the shelves collapse before it occurred. Therefore, no way in which to reach up to stop the fall. Moreover, Dr. Mall assumes Petitioner was hit in the exact right way, but such assumption is based upon correlation not causation. Specifically, Dr. Mall testified: "And so I felt that, even though there wasn't the most consistent injury mechanism with rotator cuff tearing, that there is really is no other way she could have a rotator cuff tear based on the fact that she hadn't had any prior problems in the right shoulder, and now is having significant problems. PX14, p. 19. Such opinion is based upon correlation and not causation.

Based on this finding, the Commission vacates the Arbitrator's award of medical expenses related to treatment of the right shoulder, including right rotator cuff surgery, and the award of prospective medical care consisting of physical therapy for the right shoulder.

The Commission further vacates the award of prospective temporary total disability benefits. (See *Weyer v. Illinois Workers' Compensation Commission*, 387 Ill. App. 3d 297, 307 (2008). "'Each Section 19(b) proceeding is a separate proceeding, limited to a determination of temporary total disability up to the date of hearing, and each 19(b) decision is a separate and appealable order.' quoting *R.D. Masonry, Inc.*, 215 Ill. 2d at 408 citing *Elmhurst-Chicago Stone Co. V. Industrial Comm'n*, 269 Ill. App. 3d 905, 646 N.E.2d 961, 207 Ill. Dec. 127 (1995).").

The Commission affirms the Arbitrator's finding that Petitioner's current condition of ill-being regarding her lumbar spine is causally related to the accident at work on December 1, 2015, based on Dr. Gornet's opinions as noted in his records. The Commission further affirms the Arbitrator's finding that Petitioner's current condition of ill-being regarding her cervical spine is causally related to the accident at work on March 31, 2016, based on Dr. Gornet's opinions as noted in his records. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's October 11, 2017 decision is modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $446.00 per week for a total period of 75 weeks, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act and as provided in §19(b) of the Act.

IT IS FURTHERED ORDERED BY THE COMMISSION that the award of prospective temporary total disability benefits is hereby vacated.

IT IS FURTHERED ORDERED BY THE COMMISSION that the award of medical expenses related to treatment of the right shoulder, including right rotator cuff surgery, is hereby vacated. Respondent shall pay for reasonable and necessary services related to Petitioner's condition of ill-being for her lumbar spine and cervical spine pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHERED ORDERED BY THE COMMISSION that the award of prospective medical care consisting of physical therapy for the right shoulder is hereby vacated. Respondent shall pay for reasonable and necessary prospective medical care related to Petitioner's condition of ill-being for her lumbar spine and cervical spine as recommended by Dr. Gornet.

IT IS FURTHER ORDERED BY THE COMMISION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes Respondent paid $33,704.86 in temporary total disability benefits.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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:
o04/10/18
LEC/maw
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

MOLTON, TIFFANY
Employee/Petitioner

Case# **15WC042442**

16WC011409

RED BUD REGIONAL CARE
Employer/Respondent

18IWCC0381

On 10/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.22% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4620 ADWB LLC
JOHN WINTERSCHEIDT
51 EXECUTIVE PLAZA CT
MARYVILLE, IL 62082

0075 POWER & CRONIN LTD
DANIEL J ARTMAN
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

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)

TIFFANY MOLTON
Employee/Petitioner

v.

RED BUD REGIONAL CARE
Employer/Respondent

Case # **15** WC **42442**

Consolidated cases: **16 WC 11409**

18IWCC0381

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **June 9, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **December 1, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being *is* causally related to the accident ***with regard to her lumbar spine.***

In the year preceding the injury, Petitioner earned **$34,788.00**; the average weekly wage was **$669.00**.

On the date of accident, Petitioner was **34** years of age, ***married*** 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 **$33,704.86** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$33,704.86**.

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

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being with regard to her lumbar spine is causally related to the accident at work on December 1, 2015. Petitioner's current condition of ill-being with regard to her cervical spine and right shoulder is causally related to the accident at work on March 31, 2016. Petitioner has not reached maximum medical improvement for either accident.

Respondent shall pay reasonable and necessary medical services totaling $169,130.94, which includes reimbursement to Petitioner in the amount of $41.69, as set forth in Petitioner's Exhibit 15, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay for prospective medical treatment related to her lumbar spine, cervical spine, and right shoulder, as recommended by Dr. Mall and Dr. Gornet.

Respondent shall pay Petitioner temporary total disability benefits of $446.00 per week for 75 weeks, for a total of $33,450.00 for the periods of (1) December 28, 2015, through March 26, 2016, (12 6/7 weeks) related to her accident of December 1, 2015; and (2) April 1, 2016, through June 9, 2017, the date of hearing, (62 1/7 weeks) related to her accident of March 31, 2016. Respondent shall receive credit for benefits previously paid in the amount of $33,704.86. Respondent shall pay ongoing temporary total disability benefits until such time as Petitioner's conditions allow her to return to work or until she reaches maximum medical improvement.

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

October 8, 2017
Date

ICArbDec19(b)

OCT 11 2017

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

18IWCC0381

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

TIFFANY MOLTON
Employee/Petitioner

v.

Case #: 15 WC 42442
(DOA 12/1/15)
Consolidated with
16 WC 11409
(DOA 3/31/16)

RED BUD REGIONAL CARE
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties agreed and stipulated that Petitioner sustained two separate accidents which arose out of and in the course of her employment, on December 1, 2015, and March 31, 2016. Due to the overlapping medical conditions, treating physicians, medical treatment, and claimed periods of temporary total disability benefits, the cases were previously consolidated on April 10, 2017. The disputed issues are the same in each case, that being causal connection, medical bills, prospective medical, and past and ongoing temporary total disability.

At the time of both accidents, Petitioner was 34 years old, married, and had one dependent child. She was employed by Respondent as a Licensed Practical Nurse (LPN) and had been so employed for about three-and-a-half years. In addition to dispensing medication and assisting in patient care, Petitioner is required to lift and move patients.

On **December 1, 2015**, a patient was attempting to get out of bed unassisted and started to fall. Petitioner bent over the bed to prevent the resident from falling and was pulled toward the falling patient. She felt immediate pain in her low back with pain down both of her legs.

Petitioner testified that in approximately 2002 she hurt her low back, saw a physician on one or two occasions and missed about two days from work. She has not experienced any low back problems or sought medical treatment for her low back since then. She further testified that prior to 2000, while in high school, she was riding a bus that was involved in an accident. The students were taken to a hospital and she was placed in a soft collar for about a week. She has not received any additional medical treatment for her neck since then and has never missed any time from work because of neck problems.

Petitioner testified she has never injured her right shoulder before December 1, 2015, has never received medical treatment to that shoulder, nor has she ever missed any time from work due to right shoulder problems. She has received medical attention to her *left* shoulder in the past, due to an injury she had while in high school between 1996 and 2000. She believes she saw a Dr. Burns in Perryville and her treatment included an MRI of the shoulder. Petitioner testified she is not claiming any injury to her left shoulder due to the work accidents of December 1, 2015, or March 31, 2016. She believed that an MRI of her neck may have been taken in about 2010 to 2013 in connection with diagnosing her left shoulder condition, but if it occurred, no record of such a test was entered in evidence. The Arbitrator notes that records do include a brain MRI and a left shoulder MRI done on April 10, 2015. PX5.

Petitioner reported the December 1, 2015, accident immediately and completed and signed a Report of Injury. PX1. The following day she sought medical treatment with her family physician, Dr. Lisa Lowry-Rolfing at Chester Clinic, and was seen by Physician's Assistant Jamie Hess. A history of the accident was recorded, as were Petitioner's complaints of burning pain across her low back and radiation in to her legs. Petitioner was diagnosed with a lumbar strain, prescribed medication, excused from work and allowed to return to the job the next day with restrictions of no lifting, pushing or pulling greater than 6 to 10 pounds, no climbing, repeated stooping, crawling, kneeling or working in cramped positions and no more than 20 minutes continuous walking, sitting or standing. Respondent accommodated the restrictions and Petitioner returned to work. Dr. Lowry continued to treat Petitioner and limit her activity while she underwent physical therapy at Apex Physical Therapy and worked within her restrictions. PX3, PX4. While still under Dr. Lowry's care, Respondent informed Petitioner that they could no longer accommodate her restrictions, effective December 28, 2015.

Petitioner did not improve with conservative care, and Dr. Lowry excused her from work and instructed her to continue physical therapy. A lumbar MRI was ordered, which Petitioner underwent on January 5, 2016. The MRI was interpreted as revealing focal disc pathology at the L3-4 and L5-S1 levels with suggested nerve root impingement of the S1 nerves, particularly on the left side. PX5. Due to these finding, Dr. Lowry continued to excuse Petitioner from work and referred her to Dr. Kevin Vaught in Cape Girardeau, Missouri for additional treatment. PX3.

Petitioner initially saw Dr. Vaught on January 20, 2016, and reported a consistent history of the accident and complained of low back pain down both of her legs. After reviewing the MRI, Dr. Vaught diagnosed sacroiliac joint dysfunction, left hip pain and spondylosis with lumbar radiculopathy. He recommended an MRI of the left hip and sacroiliac joint injections, and excused Petitioner from work. He further opined that Petitioner's back injury was causally related to her December 1, 2015, work accident. The left hip MRI was taken on February 18, 2016, and was pathologically negative, revealing only mild osteoarthritis of the sacroiliac joint. Physical therapy was continued. PX6, PX7.

Petitioner did not experience any improvement in her symptoms with Dr. Vaught's treatment, so at the advice of her attorney and on referral by Dr. Lowry, she presented to orthopedic surgeon Dr. Mathew Gornet on March 21, 2016. She reported a consistent history of the work accident and complained of low back pain and tightness, as well as pain down both

legs. Dr. Gornet's March 21, 2016 office note further records, "She does admit to a history of shoulder problems, which she also feels was worse after the accident. She feels that she may have aggravated this condition." With respect to his shoulder examination, Dr. Gornet recorded, "Range of motion of her shoulder on the **left** side is decreased secondary to pain. She understands this is not my area of expertise." (Emphasis added.) Dr. Gornet's March 21, 2016, office note is silent with respect to Petitioner's **right** shoulder and no referral was made for treatment of either of Petitioner's upper extremities at that time. Dr. Gornet reviewed the January 4, 2016, lumbar MRI and interpreted the films as revealing "an obvious annular tear at L3-4 as well as a central disc herniation/annular tear at L5-S1". He opined that Petitioner's low back condition was causally related to her December 1, 2015, work accident and imposed work restrictions of sedentary work only with no lifting greater than 10 pounds, no repetitive bending or lifting, and alternating between sitting and standing as needed. He also ordered epidural steroid injections at the L3-4 and L5-S1 levels. PX8.

Petitioner was allowed to return to work within Dr. Gornet's restrictions on March 25, 2016. Six days later, on **March 31, 2016**, she was standing in the nurses' station with Dr. Lowry and another LPN when a bookshelf containing binders and patient charts fell from the wall, striking her on the back of her neck and on the top scapular area of her right shoulder. As the bookshelf, charts, and binders continued to fall, Petitioner's low back was also struck by the falling shelves and their contents. She felt immediate pain in her neck and right shoulder and increased pain in her low back. Petitioner reported the accident immediately and she completed and signed a Report of Injury that day. PX2.

Petitioner was seen at the emergency room at Red Bud Regional Hospital that day. She reported a consistent history of the accident and complained of pain in her right sided neck, shoulder, and back. She underwent x-rays of her right shoulder, lumbar spine, and thoracic spine and also underwent a CT scan of her cervical spine. She was diagnosed with a back contusion, shoulder contusion, and myofascial cervical strain. She was excused from work and instructed to follow-up with her physician for medical treatment. PX9.

Petitioner contacted Dr. Gornet's office and an appointment was made for her to see him on April 5, 2016. On that day, Dr. Gornet noted Petitioner's complaints of increased low back pain, neck pain, and right shoulder and right arm pain, with numbness and weakness in her right scapular area following the March 31, 2016 accident. An MRI of the cervical spine was done, which revealed subtle disc protrusions at C4-5 and C5-6, with an obvious herniated disc at C4-5 and subtle herniation or annular tear at C5-6, and suggestion of annular tear at C3-4. Dr. Gornet opined that Petitioner's cervical spine complaints were due to her March 31, 2016, work accident and that she also aggravated her lumbar spine in that accident as well. Physical therapy was continued and Petitioner was excused from work through April 18, 2016, and allowed to return to work thereafter with restrictions. PX8, PX10.

Petitioner testified that Respondent has not allowed her to return to work with her restrictions since March 31, 2016, and that she has not worked in any capacity since then.

Petitioner continued to treat with Dr. Gornet and continued her physical therapy. She underwent lumbar epidural steroid injections by Dr. Helen Blake on April 19, 2016, and May 3, 2016, upon referral by Dr. Gornet, but her condition did not improve. PX8, PX11.

Petitioner presented to Dr. Nathan Mall on May 10, 2016, upon referral by Dr. Gornet. Dr. Mall noted that she was treating with Dr. Gornet for spinal injuries and further noted a consistent history of her March 31, 2016, work accident and complaints of right shoulder pain down her arm. He diagnosed a shoulder contusion, implemented conservative treatment consisting of a steroid injection into the shoulder and physical therapy, and imposed work restrictions. Petitioner did not improve with conservative treatment, so an arthrogram and post-arthrogram MRI of the right shoulder were performed on June 3, 2015. The tests revealed high grade partial thickness interstitial tearing of the distal and insertional fibers of the supraspinatus tendon without full thickness tearing, bicipital tendinosis with partial thickness interstitial tearing and a small amount of fluid within the subacromial/subdeltoid bursa suggesting mild bursitis. Following the arthrogram, Dr. Mall diagnosed a rotator cuff tear and acromioclavicular strain, which he opined were causally related to Petitioner's work accident of March 31, 2016. He recommended shoulder surgery and continued to impose work restrictions. PX13, PX10.

Respondent obtained a Utilization Review (UR) of Dr. Mall's recommended surgery and the surgical request was denied on July 29, 2016. PX16. The denial was appealed.

While Petitioner awaited surgical approval, she continued to treat with Dr. Gornet for her cervical and lumbar injuries. At the direction of Dr. Gornet, she underwent epidural steroid injections in her neck at C4-5 and C5-6 by Dr. Helen Blake on July 5 and 19, 2016. PX11. She continued her physical therapy. PX4.

On August 25, 2016, Dr. Gornet voiced his plan to conservatively treat Petitioner's cervical and lumbar spinal injuries until she completed her shoulder treatment with Dr. Mall. In the meantime, he maintained Petitioner's light duty status relative to her spinal conditions. PX8.

On August 30, 2016, a UR Appeal Review report was issued, which certified Dr. Mall's recommended surgery. PX17. Dr. Mall performed right shoulder surgery on September 9, 2016, consisting of arthroscopic rotator cuff repair of the supraspinatus tendon and the subscapularis tendon; a subacromial decompression and acromioplasty; a subcoracoid decompression and coracoplasty; an acromioclavicular joint resection, and a biceps tenotomy. Petitioner was excused from work following the surgery and physical therapy was again instituted. Petitioner continued to treat with Dr. Mall following the surgery and he has continued to place work restrictions on her while her strength and mobility improve through physical therapy. PX12.

Petitioner's neck and low back pain and radicular symptoms have continued unabated and she continues to see Dr. Gornet for those conditions while she recovers from her shoulder injury. Dr. Gornet ordered a repeat lumbar MRI that occurred on February 13, 2017, and a repeat cervical MRI that occurred on April 24, 2017. The lumbar MRI confirmed the disc herniations or annular tears at the L3-4 and L5-S1 levels. Dr. Gornet also advised Petitioner to continue to lose weight (she has lost over 20 pounds at Dr. Gornet's request). The repeat cervical MRI confirmed central C6-7 and C5-6 annular tears, each causing spinal cord contact,

and separate bilateral foraminal protrusions at C5-6 resulting in moderate bilateral foraminal stenosis, bilateral foraminal C4-5 disc protrusions resulting in right-greater-than-left foraminal stenosis and a small central C3-4 protrusion causing dural displacement. PX8, PX10.

Petitioner last saw Dr. Gornet on April 24, 2017, at which time he restricted her to sedentary/office duty only, with specific work restrictions of no lifting greater than 10 pounds, alternating sitting and standing as needed, no repetitive bending, and no repetitive lifting. Dr. Gornet encouraged Petitioner to find work within her restrictions. PX8.

Petitioner last saw Dr. Mall on May 19, 2017, at which time she continued to complain of pain in the superior aspect of her shoulder with weakness during rotator cuff testing. He recommended continued physical therapy and placed restrictions of avoiding constant use of the right upper extremity, primarily one-handed work with the injured extremity used to assist with light tasks, no pushing or pulling over two pounds at waist level, no overhead lifting and no lifting greater than 10 pounds. PX14. Petitioner testified she is scheduled to see Dr. Mall again in about two months.

Petitioner testified that her recovery from shoulder surgery has been slow and is not complete. As of January 31, 2017, Respondent would not authorize additional physical therapy. She was examined by Dr. Frank Petkovich on February 22, 2016, for her cervical and lumbar injuries and by Dr. Michael Nogalski on February 27, 2017, for her shoulder injury, pursuant to Section 12 of the Act. Following her examinations, Petitioner was instructed to return to work on March 21, 2017. She testified she did so on that date, but was sent home, after being told that Respondent would not accommodate non-work related restrictions.

Dr. Petkovich testified by way of deposition on June 8, 2017. He is a Board Certified Orthopedic Surgeon who performed spinal surgeries from 1980 until four or five years ago. He stopped performing surgeries at that time due to issues with his eye, which necessitated several surgeries. He continues to have an office-based orthopedic practice and additionally performs independent medical evaluations, which account for 15-20% of his practice. RX3.

Dr. Petkovich testified that upon examination, Petitioner's only subjective complaints were of intermittent discomfort in the neck and low back and that she did not describe any true radicular symptoms. Her clinical examination was essentially normal, which was consistent with his review of the cervical and lumbar MRI films. He testified that Petitioner did not have any annular tears or disc herniations. He further testified that, while obtaining the original cervical and lumbar MRI's was reasonable, obtaining the repeat cervical and lumbar MRI's was not reasonable or necessary. He explained this was because Petitioner reached maximum medical improvement within 6 weeks of each date of accident, and because there was no medical evidence to suggest that repeat MRI's was necessary. He noted Petitioner's clinical symptoms and subjective complaints had not changed from her first visit with Dr. Gornet until the time he recommended the updated MRI's of the cervical and lumbar spines. RX3.

On cross-examination, Dr. Petkovich acknowledged that Petitioner completed a Patient Intake Form before her examination, on which she noted her symptoms of pain in the neck, low back, and right shoulder, with radicular symptoms down her right arm and into both legs.

Despite these noted symptoms, Dr. Petkovich testified that Petitioner voiced only intermittent discomfort in her neck and low back, as well as intermittent discomfort in her upper and lower extremities without any true radicular symptoms. He conceded that his examination of Petitioner revealed discomfort at extreme ranges of cervical motion and some tenderness to palpation in the right and left paraspinous cervical areas. His lumbar examination revealed a range of motion limited to 70 degrees flexion, extension 0 degrees, and left and right bends each at 10 degrees with discomfort at the extremes. Palpation resulted in complaints of tenderness in the right paraspinous area. Straight leg raise produced hamstring pulling at 80 degrees with no radicular symptoms. RX3.

Continuing on cross-examination, Dr. Petkovich testified that he found tenderness but no neck pain on either side of Petitoner's cervical spine, no complaints of pain from her neck down into the back of her right shoulder, and no complaints of tingling from her neck down her arm. RX3. The Arbitrator notes that all of these complaints were recorded by Respondent's second Section 12 examiner, Dr. Nogalski, five days after the evaluation by Dr. Petkovich. RX3.

Dr. Petkovich reviewed Petitioner's x-rays and interpreted them as showing "very mild" degenerative changes, and he testified this would be consistent with her history of "minimal complaint or no complaint" of neck or low back pain prior to December 1, 2015. Dr. Petkovich reviewed Petitioner's lumbar MRI's of January 4, 2016, and February 13, 2017, and her cervical MRI's of April 5, 2016, and April 24, 2017. He testified that his interpretation of all four MRI's was that the findings were "chronic and unrelated" to Petitioner's accidents of December 1, 2015, and March 31, 2016. RX3

Dr. Petkovich testified that he found Petitioner to be pleasant and cooperative with his examination. Following his evaluation and review of the medical records, he testified that Petitioner sustained a cervical and a lumbar strain secondary to her work accidents, and that she reached maximum medical improvement six weeks after each accident. He testified she requires no additional treatment or diagnostic studies for her neck or low back and that any complaints she presently has are related to the mild degenerative changes in her cervical and lumbar spine. Finally, Dr. Petkovich testified that Petitioner can work without restrictions relative to her neck and low back. Dr. Petkovich expressed no opinions regarding Petitioner's *right shoulder*, nor did he express any opinions about any work restrictions or additional medical treatment necessitated by her right shoulder. Likewise, he did not review Dr. Nogalski's report prepared on behalf of Respondent. He did, however, acknowledge the overlap of shoulder and neck symptoms following a cervical spine injury, in conformity with the testimony of Dr. Nogalski and Dr. Mall as indicated below. RX3.

Five days after Dr. Petkovich's evaluation, Petitioner was examined by Dr. Nogalski on February 27, 2017. Dr. Nogalski testified by way of deposition on May 22, 2017. He is a Board Certified Orthopedic Surgeon. He testified that in connection with Petitioner's examination, he reviewed records from Red Bud Regional Hospital, Dr. Gornet, MRI Partners of Chesterfield, Orthopedic Ambulatory Surgery Center, Dr. Blake, Dr. Mall and Apex Physical Therapy. RX1.

Dr. Nogalski found Petitioner to be pleasant and cooperative with his examination and found no signs of symptom magnification or malingering. He testified that during his physical

examination, Petitioner voiced complaints of pain in the top and front of her right shoulder with pain in both sides of her cervical spine and pain that traveled to the back of her shoulder. Petitioner had difficulty moving her neck and shoulder together. She had difficulty using her arm to shift her vehicle from park to drive, difficulty fastening her bra or reaching around her back, and problems when she attempted to reach away from or hold objects away from her body. Petitioner felt she had lost strength in her arm and experienced tingling sensations that traveled from her neck into her arm, occasionally to her thumb, index and middle fingers. RX1.

Dr. Nogalski testified that based on his examination and review of records, Petitioner sustained a right neck and posterior superior shoulder contusion secondary to her accident of March 31, 2016, with a history of pre-existing bilateral shoulder problems. Dr. Nogalski opined that Petitioner's present right shoulder complaints are not causally related to her March 31, 2016, work accident for two reasons: (1) the mechanism of Petitioner's accident—impact to the back of the shoulder and neck areas—does not correlate with the MRI findings, thus rendering it impossible to injure a rotator cuff to the degree necessitating surgery; and (2) Petitioner's rotator cuff issues pre-existed her March 31, 2016, accident as documented by Dr. Gornet's office note of March 21, 2016. Other than that one specific office note, Dr. Nogalski had not seen any other medical records reflecting right shoulder complaints before March 31, 2016. Based upon those premises, Dr. Nogalski testified that Petitioner's shoulder surgery was not necessitated by her work injury and further testified that she had reached maximum medical improvement for any shoulder injury sustained in the March 31, 2016, accident. RX1.

Dr. Nogalski testified that Petitioner currently requires work restrictions of no lifting greater than ten pounds and no use of her right arm above shoulder level; however, he further testified that she can work without restrictions secondary to any shoulder injury she sustained on March 31, 2016. Dr. Nogalski also testified that Petitioner may require additional treatment for her shoulder that may include additional physical therapy. Finally, Dr. Nogalski opined that Petitioner requires restrictions secondary to her cervical conditions in addition to the right shoulder restrictions outlined above. RX1.

Like Dr. Petkovich, Dr. Nogalski testified that an overlap exists between symptoms secondary to shoulder injuries and cervical spine injuries. He explained that in this case, Petitioner's complaints of pain on both sides of her neck could be related to a cervical spine injury sustained on March 31, 2016, and that he would defer to a qualified spinal surgeon with respect to appropriate treatment modalities for those symptoms. He testified that, likewise, Petitioner's complaints of pain from the back of her neck into the back of her shoulder can be related to a cervical spine injury and that he would also defer treatment recommendations for that symptom to her treating spinal surgeon. Finally, he testified that Petitioner's complaints of tingling sensations from her neck down her arm, occasionally to her thumb, index and middle finger can be related to a cervical spine injury and that he would defer to a spinal surgeon for treatment of those symptoms as well. RX1.

Dr. Nogalski testified that he had no reason to question Dr. Mall's finding of a full thickness rotator cuff tear during his September 8, 2016, surgery. He agreed with Dr. Gornet's decision to defer any further treatment of Petitioner's cervical and lumbar spinal conditions until Petitioner completed her shoulder treatment. RX1.

Dr. Mall testified by way of deposition on May 1, 2017. He is a Board Certified Orthopedic Surgeon. He testified that he originally saw Petitioner on May 20, 2016, on referral from Dr. Gornet. His examination of Petitioner's right shoulder revealed pain with rotator cuff testing and weakness in three of the four tendons of the rotator cuff, when compared to the exam and testing of her left shoulder. Dr. Mall explained that the supraspinatus, infraspinatus and subscapularis are three of the four tendons that make up the rotator cuff. Petitioner also had acromioclavicular joint pain. Like Dr. Petkovich and Dr. Nogalski, Dr. Mall explained that considerable overlap exists between shoulder and cervical spine symptoms, including Petitioner's complaints of pain down her right arm. Based upon Petitioner's age and the statistical unlikelihood of a rotator cuff tear being present in someone of her age, Dr. Mall's tentative diagnosis was that of an AC joint contusion and right shoulder contusion. As such, he administered an AC joint injection, prescribed anti-inflammatory medication, ordered physical therapy and imposed the work restrictions referenced above. PX14.

Dr. Mall testified that when Petitioner did not improve with conservative measures, she underwent the arthrogram and post-arthrogram MRI referenced above, which he personally read. Based on the findings, Dr. Mall diagnosed a rotator cuff tear, AC joint sprain, and biceps tendonitis and he recommended surgery. Work restrictions were continued while Respondent's UR's confirmed the necessity of his recommended surgery. PX14.

Dr. Mall testified that Petitioner's right shoulder conditions he diagnosed were causally related to her injury of March 31, 2016. He acknowledged that Petitioner's mechanism of injury is not the most consistent cause of rotator cuff tearing, and based his opinion on the fact that an asymptomatic rotator cuff tear in someone Petitioner's age is "almost unheard of" and therefore, "there is really no other way she could have a rotator cuff tear given the fact that she hadn't had any prior problems in the right shoulder, and is now having significant problems." Dr. Mall testified that based upon medical studies focusing on rotator cuff tears, which he had actually participated in, less than one percent of people Petitioner's age experience a rotator cuff tear without injury. He further testified that if Petitioner was in that "less than one percent" that had an asymptomatic rotator cuff tear, the March 31, 2016 accident appeared to have aggravated that condition to make it symptomatic. PX14.

Dr. Mall testified that following UR certification, he performed surgery on Petitioner on September 8, 2016. During that surgery, he viewed the upper boarder subscapularis tear and a rotator cuff tear on the supraspinatus tendon. The surgical viewing also revealed blood in the tendon, which is indicative of acute tearing. Following repair of the rotator cuff tear and biceps tendinosis, Dr. Mall excused Petitioner from work. He subsequently allowed her to return to work with restrictions, which Respondent could not accommodate. Dr. Mall testified that Petitioner showed post-surgical improvement with physical therapy until Respondent denied authorization for further treatment as of January 31, 2017. PX14.

In accord with Dr. Nogalski's testimony, Dr. Mall's testified to his belief that Petitioner would benefit from more therapy to increase her strength to the level that will allow her to return to work. Only if Petitioner continues to experience weakness after additional physical therapy would he recommend a repeat MRI of the shoulder. PX14.

As a result of her work-related injuries, Petitioner has incurred medical bills totaling $169,130.94. Of that amount, Respondent has paid $28,139.92, medical insurance has paid $704.43, Petitioner has paid $41.69, and $78,272.43 remains outstanding.

With respect to her **low back**, Petitioner testified that she feels a "pretty constant" burning pain in her low back. She experiences numbness down her legs and finds it painful to sit for extended periods of time, particularly on hard chairs. She can ride short distances in a car, but after a while her pain increases. She has difficulty bending, squatting and using stairs and her discomfort increases when she walks distances. She testified that when her legs go numb she loses her balance and in fact has fallen as a result, as noted in the physical therapy note of October 28, 2016.

With respect to her **right shoulder**, Petitioner testified that Dr. Mall's surgery alleviated the pain she initially felt after her accident, but she now experiences a different type of pain, not nearly as severe, that she believes is post-surgical in nature. The pain is now in the front of her shoulder and the outer side of her shoulder "all the time." She feels a catch in her shoulder and the joint always feels tight. She has lost strength in her right arm to the degree that she cannot lift a gallon of milk to shoulder level with her arm extended and has trouble using the steering-post-mounted, automatic gear shift on her vehicle with her right arm. She still has significant loss of range of motion, and has difficulty tucking in her shirt behind her back with her right hand and difficulty fastening her bra behind her back with that hand. She is unable to sleep comfortably due to the pain in her right shoulder.

With respect to her **neck**, Petitioner testified she has pain and tightness in the right side of her neck to her shoulder on a daily basis. She frequently experiences tingling and a burning sensation from her neck down into her right arm to her fingers. She experiences headaches and has limited range of motion.

Petitioner testified that the physical therapy has helped her shoulder and she would like to continue that treatment, as recommended by Dr. Mall. She would also like to have her neck and low back conditions addressed by Dr. Gornet when she recovers from her shoulder injury.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The parties stipulated that Petitioner sustained accidents on December 1, 2015, and March 31, 2016, which arose out of and in the course of her employment. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

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

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

With both accidents admitted, causation of Petitioner's low back condition secondary to the December 1, 2015, accident and her right shoulder and neck conditions secondary to the March 31, 2016, accident is at the heart of the disputes being litigated herein. Putting an even finer point on the dispute, there is no question that Petitioner injured her low back on December 1, 2015, and no question that she injured her shoulder and neck in the accident of March 31, 2016. The disagreement rests upon the nature of those injuries and the treatment necessary resulting therefrom.

With respect to Petitioner's **December 1, 2015, low back injury**, the day after her accident, she sought medical treatment and has thereafter recited a consistent history of accident with uniform complaints of burning pain across her low back and radiation into her legs. Since then she has either been excused from work or under work restrictions due to her accident. The lumbar MRI of January 5, 2016, revealed focal disc pathology at the L3-4 and L5-S1 levels with suggested nerve root impingement of the S1 nerves, particularly on the left side. That diagnosis has remained essentially unchanged since.

Petitioner initially saw Dr. Gornet on March 21, 2016, at which time he interpreted the MRI films as revealing an obvious annular tear at L3-4 and a central disc herniation or annular tear at the L5-S1 level. Dr. Gornet ordered epidural steroid injections, but before they took place Petitioner unfortunately injured her neck and right shoulder in the March 31, 2016, accident. At that time Dr. Gornet decided to delay addressing Petitioner's spinal conditions until she completed her shoulder treatment. Dr. Nogalski, Respondent's Section 12 examiner, testified that he agreed with Dr. Gornet's decision. As a result, Petitioner's low back condition (and cervical condition following her March 31, 2016 accident), have essentially gone untreated.

Despite the opinions of Dr. Gornet and Dr. Nogalski, Respondent's denial of further treatment for Petitioner's lumbar and cervical conditions is based solely upon the testimony of its other Section 12 examiner, Dr. Petkovich, who opined without elaboration that Petitioner reached maximum medical improvement six weeks after each of her work accidents. The Arbitrator finds Dr. Petkovich's opinion to be concerning on several levels.

First, Dr. Petkovich's record of Petitioner's symptoms does not match the pain diagram Petitioner completed on the Patient Intake Form on the day of his exam. Second, Dr. Petkovich saw Petitioner five days before Dr. Nogalski, but failed to record Petitioner's symptoms and complaints of pain on both sides of her neck, her complaints of pain from the back of her neck into the back of her shoulder, or her complaints of tingling sensations from her neck down her arm, occasionally to her thumb, index and middle finger, all of which were recorded five days later by Dr. Nogalski. Dr. Nogalski testified that all of these symptoms can be related to the cervical spine injury sustained on March 31, 2016, and further testified that he would defer to a qualified treating spinal surgeon with respect to appropriate treatment modalities for those symptoms. Finally, perhaps most troubling is Dr. Petkovich's interpretation of four different sets of MRI films taken of Petitioner's cervical and lumbar spine regions. With very little variance,

his review of each set of films generated the conclusion that "All of the findings on this MRI lumbar [or "cervical"] spine are in fact chronic and unrelated to either of the above incidents [Petitioner] described as occurring while at work on December 1, 2015 and March 31, 2016."

Like Dr. Vaught's opinion of January 20, 2016, that Petitioner's complaints were due to her work injury and that she needed additional treatment for her injuries, Dr. Gornet also agreed that Petitioner's spinal conditions were secondary to her work injuries and that she remained in need of additional treatment. Dr. Nogalski further agreed that Petitioner's symptoms should be addressed by her spinal surgeon and that she required work restrictions secondary to her cervical spine injures.

Finally, Petitioner has no history of significant low back or neck problems and could perform the strenuous duties required of an LPN up to the date of her December 1, 2015, accident. She is now unable to do so.

The Arbitrator finds the opinions of Dr. Vaught, Dr. Gornet and Dr. Nogalski to be more persuasive that those of Dr. Petkovich. The Arbitrator further finds that Petitioner's **low back** conditions, as diagnosed by Dr. Gornet are causally related to her **December 1, 2015**, work injury and that her **cervical conditions**, as diagnosed by Dr. Gornet, are causally related to her **March 31, 2016**, work injury.

With respect to Petitioner's **right shoulder** injury, Respondent's denial of further medical treatment is based upon Dr. Nogalski's opinion that Petitioner's right shoulder complaints are not causally related to her March 31, 2016, work accident, an opinion which he based upon two premises: (1) the mechanism of Petitioner's accident/injury do not correlate with the MRI findings, thus rendering it impossible to injure a rotator cuff to the degree necessitating surgery; and (2) Petitioner's rotator cuff issues pre-existed March 31, 2016, as documented by Dr. Gornet's office note of March 21, 2016.

Addressing Dr. Nogalski's concerns in reverse order, it is apparent that Respondent's reliance upon Dr. Gornet's March 21, 2016, office note for the proposition that Petitioner had pre-existing right shoulder problems is misplaced. In pertinent part, that office record states, "She does admit to a history of shoulder problems, which she also feels was worse after the accident. She feels that she may have aggravated this condition." The Patient Intake Form with a pain diagram completed by Petitioner that day contains no indication of *right* shoulder problems. In accord therewith, Dr. Gornet examined only Petitioner's *left* shoulder, which is consistent with Petitioner's testimony and medical records concerning prior *left* shoulder problems. Nowhere, in any medical record or from any source, is there any mention of *right* shoulder problems or treatment pre-existing either of Petitioner's work accidents.

Regarding the remaining basis for Dr. Nogalski's opinion, Dr. Mall readily acknowledged that Petitioner's mechanism of injury was not the usual cause of rotator cuff tearing. With that in mind, he based his opinion on the fact that asymptomatic rotator cuff tears in someone Petitioner's age were "almost unheard of" and therefore, "there is really no other way she could have a rotator cuff tear based on the fact that she hadn't had any prior problems in the right shoulder, and is now having significant problems." He supported this conclusion with

medical studies establishing that less than one percent of people Petitioner's age experience a rotator cuff tear without injury. In Dr. Mall's opinion, if Petitioner was in that "less than one percent" that had an asymptomatic rotator cuff tear, the March 31, 2016, accident appeared to have aggravated that condition to make it symptomatic. Dr. Nogalski offered no rebuttal to those studies and statistics, and simply rested his position on his opinion that it was impossible for Petitioner to have torn her rotator cuff in the accident of March 31, 2016. He offered no explanation of how the condition could become surgical one day and have been asymptomatic the day before.

For these reasons, the Arbitrator finds Dr. Mall's testimony to be persuasive and further finds that Petitioner's present condition of ill-being relative to her right shoulder is causally related to her work injury of March 31, 2016.

Finally, it bears mentioning that Petitioner's shoulder surgery was delayed more than three months while Respondent exercised its right to have the surgical recommendation undergo a Utilization Review by a physician of its choice. It was not until the UR found that Dr. Mall's proposed right shoulder surgery was reasonable and necessary that Respondent authorized the procedure. It is disingenuous for Respondent to now claim that the surgery is unrelated to the injury after initially authorizing the procedure following its Utilization Review.

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

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

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that medical services rendered to date were reasonable and necessary in Petitioner's care and treatment relative to her accidents of December 1, 2015, and March 31, 2016. The Arbitrator finds that Respondent is liable for medical bills of $169,130.94, which includes reimbursement to Petitioner in the amount of $41.69, as set forth in Petitioner's Exhibit 15, subject to the medical fee schedule as provided in Section 8(a) and 8.2 of the Act. Respondent is entitled to credit for all payments previously made to providers. The Arbitrator notes that Respondent did not claim a credit under Section 8(j).

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

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary medical care required by their employees. Specific medical procedures or treatment that have been prescribed by a

medical service provider have been "incurred" within the meaning of the statute, even if they have not yet been paid for. *Plantation Mfg. Co. v. Industrial Commission*, 294 Ill.App.3d 705, 710 (2nd Dist. 1997).

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that Petitioner is not currently at maximum medical improvement for any the injuries sustained in either of her accidents. Dr. Mall, Dr. Gornet, and Dr. Nogalski all agree that Petitioner requires additional medical treatment. It is only Dr. Petkovich who disagrees and opined that Petitioner reached maximum medical improvement six weeks after each of her accidents.

With regard to Petitioner's **right shoulder**, Dr. Mall has recommended additional physical therapy. Though he disagreed with causation, Dr. Nogalski nonetheless testified that Petitioner may require additional treatment for her shoulder, which may include physical therapy. The Arbitrator finds Respondent is liable for prospective medical care for Petitioner's right shoulder injury sustained on March 31, 2016.

With regard to Petitioner's **cervical and lumbar** injuries, Dr. Gornet is considering a lumbar discogram, but all substantive medical treatment for both the neck and low back remains on hold until Petitioner completes her shoulder treatment. Dr. Nogalski agreed with this approach. Further, Dr. Nogalski testified that Petitioner's complaints of pain on both sides of her neck, her complaints of pain from the back of her neck into the back of her shoulder, and her complaints of tingling sensations from her neck down into her arm and occasionally to her thumb, index, and middle fingers, should all be addressed by her treating spinal surgeon. The Arbitrator finds Respondent is liable for prospective medical care for Petitioner's cervical injury sustained on March 31, 2016, and her lumbar injury sustained on December 1, 2015.

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

In order to be eligible for temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill.App.3d 1087, 1090 (1996).

The parties agreed and stipulated that Petitioner was temporarily and totally disabled from December 28, 2015, through March 26, 2016, and April 1, 2016, through March 14, 2017, a period of 60 1/7 weeks. Petitioner claims an additional period from March 15, 2017, through June 3, 2017, a period of 14 5/7 weeks.

With regard to Petitioner's **cervical and lumbar** injuries, Dr. Gornet has imposed restrictions on Petitioner during the disputed period above, which Respondent will not accommodate. Though he disputed causation, Dr. Nogalski testified on behalf of Respondent that Petitioner requires restrictions secondary to her cervical condition.

With regard to Petitioner's **right shoulder**, Dr. Mall has likewise imposed restrictions on Petitioner during the disputed period above, which Respondent will not accommodate. Though

he disputed causation, Dr. Nogalski testified on behalf of Respondent that Petitioner requires restrictions of no lifting greater than ten pounds and no use of her right arm above shoulder level.

The Arbitrator finds that Petitioner was temporarily and totally disabled for two time periods, for a total of 75 weeks:

1. 12/28/15-3/26/16, related to her accident of December 1, 2015, 12 6/7 weeks
2. 4/1/16-6/9/17(date of hearing), related to her accident of March 31, 2016, 62 1/7 weeks

Having previously found that Petitioner has not yet reached maximum medical improvement from either the December 1, 2015, or the March 31, 2016, accident, the Arbitrator finds that Petitioner is therefore entitled to ongoing temporary total disability benefits, until such time as her conditions allow her to return to work or until she reaches maximum medical improvement.

The Arbitrator is mindful that Petitioner is not entitled to TTD benefits from both accidents at the same time, which would amount to a double recovery. Dr. Mall, Dr. Gornet, and Dr. Nogalski agreed that Petitioner needed to complete shoulder treatment before undergoing further substantive treatment for her cervical or lumbar injuries. In that such treatment for the shoulder has not yet been completed, the Arbitrator finds that Petitioner is currently entitled to TTD benefits related to her March 31, 2016, accident.

The parties stipulated that Petitioner's average weekly wage was $669.00, and the Arbitrator finds that her temporary total disability rate is $446.00. The Arbitrator finds that Respondent is liable for 75 weeks of temporary total disability benefits of $33,450.00. The parties stipulated and the Arbitrator finds that Respondent previously paid TTD benefits of $33,704.86 and is entitled to a credit in that amount.

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

MOLTON, TIFFANY
Employee/Petitioner

Case# **16WC011409**

15WC042442

RED BUD REGIONAL CARE
Employer/Respondent

18IWCC0381

On 10/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.22% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4620 ADWB LLC
JOHN WINTERSCHEIDT
51 EXECUTIVE PLAZA CT
MARYVILLE, IL 62082

0075 POWER & CRONIN LTD
DANIEL J ARTMAN
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

18IWCC0381

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)

TIFFANY MOLTON
Employee/Petitioner

v.

RED BUD REGIONAL CARE
Employer/Respondent

Case # 16 WC 11409

Consolidated cases: 15 WC 42442

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **June 9, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **March 31, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being *is* causally related to the accident ***with regard to her cervical spine and right shoulder***

In the year preceding the injury, Petitioner earned **$34,788.00**; the average weekly wage was **$669.00**.

On the date of accident, Petitioner was **34** years of age, *married* 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 **$33,704.96** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$33,704.96**.

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

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being with regard to her cervical spine and right shoulder is causally related to the accident of March 31, 2016. Petitioner's current condition of ill-being with regard to her lumbar spine is causally related to the accident of December 1, 2015. Petitioner has not reached maximum medical improvement for either accident.

Respondent shall pay reasonable and necessary medical services totaling $169,130.94, which includes reimbursement to Petitioner in the amount of $41.69, as set forth in Petitioner's Exhibit 15, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay for prospective medical treatment related to her lumbar spine, cervical spine, and right shoulder, as recommended by Dr. Mall and Dr. Gornet.

Respondent shall pay Petitioner temporary total disability benefits of $446.00 per week for 75 weeks, for a total of $33,450.00 for the periods of (1) December 28, 2015, through March 26, 2016, (12 6/7 weeks) related to her accident of December 1, 2015; and (2) April 1, 2016, through June 9, 2017, the date of hearing, (62 1/7 weeks) related to her accident of March 31, 2016. Respondent shall receive credit for benefits previously paid in the amount of $33,704.86. Respondent shall pay ongoing temporary total disability benefits until such time as Petitioner's conditions allow her to return to work or until she reaches maximum medical improvement.

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

October 8, 2017
Date

ICArbDec19(b)

OCT 11 2017

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 correct clerical error	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Karen Rollinson,

Petitioner,

vs.

NO: 16 WC 00373

Juno Lighting Group,

Respondent.

18IWCC0382

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, temporary total disability, medical expenses, and permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, except for correction of clerical error, which is attached hereto and made a part hereof.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 45-year-old employee of Respondent, who described her job as an assembly line operator. Petitioner had started working at Respondent May 2015. She had worked 40 hours per week, Monday through Friday, 2nd shift, 4:00pm to 12:30am. The nature of the business was recessed lighting. Petitioner stated they had different cells she worked in making the canned lighting. She testified you started on one end with the can and a sticker is put on and then a rivet in 2 spots and then the lid on and rivet that on 2 sides, then to the next station. There were 8-9 total stations. Some cells had an extra station for putting plastic pieces on the wires. Petitioner stated she was supposed to work different stations but she was always moved back to the same station. Again, station one was putting on the stickers. She stated there was a cart next to her and a bar overhead and they would be sitting on a bar roll. She stated if standing that was above her head to her right. Petitioner

is left-hand dominant. She pulled of stickers to place 2 on each can. Petitioner testified she was 1-2 hours at that station, depending on everyone else in the cell. Sometimes they would change every hour or every 2 hours. Each hour she would handle 90-100 cans and place stickers on them. Each time she reached to the right, grabbing 1 or 2 stickers at a time with her left hand. She stated she would reach up and over and hold the end paper the sticker was on and peel it off and then bring it back down. She stated it was above her eye level. After the stickers were placed she used a rivet gun to rivet the can together and it was a press and she would activate using a foot pedal while holding the side; that was at about chest high level. She had to put the lid on and rivet that together at the same station. The can then went to the next station to put in the light fixture; she had never worked at that station. There were 'made in USA' stickers at the 3rd station. Those were on a pole a little over her chest height and she had to reach over and grab that. At station 3 it was in front of her about shoulder level. Also at station 3 they had a screw gun to insert a screw; the gun was hanging on a cord above her head, about eye level so she had to pull it down to the table and twist to screw it. Pressing down; it was an automatic screw gun. It was then sent to the next station. At that station, she would do 90-100 cans per hour. Petitioner testified at station 4 they would take the parts for the inside of the can (one had a curl) and those were riveted with a foot pedal with the part on the table; they did 2 rivets. Petitioner testified tat she did not work at that station very often. There were 4 pieces put together at that station. At station 5 Petitioner stated they would take the can, metal frame and set it to not move and put a rectangular frame on it and pull down the screw gun and screw in 3 screws. At that station the screw gun is to the left so she had to twist to get it. The gun was above her eye level otherwise it would be hitting pieces. The head of the screw gun was L-shaped to the left; it was set for right hand people. When she pulled it down she had to twist to make the head fit. Her arm position there was bent in and curved up more towards the ceiling; elbow at shoulder level. Petitioner stated once the parts were secure there they had to flip it and there was a conduit for the wires that had to be inserted and bend it to insert it; the wires are put through the conduit. You had to jiggle the wires to make it click and then it would go to the next station. The putting in the conduit was done at about stomach level; she did 90-10 cans per hour at that station. Petitioner would then move to station 6 and there were yellow pieces to put on the ends of the wires and coiled them and put a metal lid on; like an electrical box, and put a sticker on it and then to the next station. That work was done at stomach level; she did not work that station very often. Station 7 was putting in the light fixture molding; a metal piece to keep it in place with the aluminum bars and smack them onto tracks and there was a paddle and another screw gun; that was above her head level. She would process 90-100 cans per hour at that station. From there they went on to packing and she never worked at station 8 packing.

- Petitioner stated they would rotate about every 2 hours and if someone was backed up on station 5 she would be moved back to get them caught back up, so she did not last at other stations long. She had mostly worked at station 5, up to 6 hours per day beginning in early September. She stated the lines always changes with people so she would end up at station 5 as other people were slow and could not keep up and Petitioner was faster. While others were rotating she would spend up to 6 hours on station 5.

- Petitioner testified that she first started noticing left arm symptoms the 2nd week in September and that was associated with pulling down the screw gun and twisting her arm to insert the screws. Petitioner testified that October 2, 2015she told her supervisor, Gustavo, and her lead operator, Christian, about her left arm symptoms. Petitioner stated they both kept her in the same area and they did not send her to HR or fill out any paperwork. Petitioner stated it was not until she went to the hospital October 2, 2015-(manifestation/DX date) that paperwork was done; she went then because she could not stand the pain anymore. Petitioner first went to Alexian Brothers Medical Group, immediate care facility. Petitioner agreed there they asked what happened to her left arm. Petitioner was prescribed Naprosyn and they released her to light duty. Petitioner returned to work the next day and she had to fill out an accident report and gave it to Gustavo; she believed that was October 3, 2015. She sat with the safety lady-(Ms. Folmer) filling out the form. Petitioner had a follow up appointment at Alexian October 5, 2015 and they prescribed Norco. She did not recall if they placed light restrictions then. When she went to the ER October 15, 2015 restrictions were placed on her and part of that was nothing repetitive. Petitioner testified she returned to work with the restriction and they had her doing the same thing all day long. Petitioner then was working with plastic pieces away from everyone else. Petitioner again returned to Alexian October 17 and October 22, 2015 and they placed her on modified duty which included no work above shoulder level and at that point Respondent could not accommodate the restrictions as of October 22, 2015. She was at Alexian October 23 and 29, 2015 and they referred her for occupational therapy. Petitioner returned to Alexian November 5, 18, 25 and December 2, 2015 and she received the therapy there.

- Petitioner was sent for an IME to Dr. Baxamusa by Respondent December 3, 2015 and Petitioner stated she was with the doctor maybe for 10 minutes and the doctor did not ask her about activities at work or different positions or job rotation or anything regarding specific activities she did at work. She followed up after that, at Alexian, with Dr. James December 16, 23, 2015 and January 6, 13, 2016 and at that time Dr. James recommended a left shoulder MRI and provided her with work restrictions. The MRI was never authorized by WC. On January 6, 2016 Dr. James then suggested that Petitioner follow up with her own doctor and that she did need additional work-up for her left shoulder. Petitioner had an MRI at Holy Family Medical Center on February 1, 2016. She did see Dr. James February 3, 2016 and Dr. James advised Petitioner that they had denied her claim and Petitioner needed to follow up elsewhere. Petitioner was evaluated by Dr. Tonino February 11, 2016 and the doctor gave her a cortisone injection to her left shoulder, and he continued the work restrictions and further therapy. Petitioner agreed Dr. Tonino did surgery on her left shoulder March 16, 2016. She had follow ups March 19 and April 21 and the doctor order more therapy at Alexian that started April 28, 2016. Petitioner had follow ups and therapy and was discharged from therapy August 10, 2016. Petitioner last saw Dr. Tonino September 29, 2016 and she was released with no restrictions. Petitioner had received a phone call from Respondent-(Marta in HR) June 3, 2016 regarding her light duty restriction. Marta advised her they then had restricted work-(light per Tonino then) for Petitioner but she had to pass a drug test first. Petitioner stated the day she was to go for the drug test she was offered a better job that was less physical so she called Respondent and let them know she was not returning to Respondent as she found a job better suited to

her condition/health needs. Petitioner went to Dr. Baxamusa for an IME and she stated she had worked as an airline detailer for only one year not 2 as noted by that doctor. In that job she had vacuumed planes that were charter and private planes, and she would restock soda and juice and liquor and snacks and clean windows. Petitioner stated that job did not involve any overhead work.

- Petitioner testified that prior to October 2015 she never had left shoulder problems and had never injured her left shoulder or have any medical care for her left shoulder. Petitioner currently works for Saint-Gobain making silicon medical parts for medical devices; started there October 2016. She works 40 hours per week, Friday through Tuesday, 6:30am to 3:00pm and makes $14.71 per hour. Regarding her left arm/shoulder, Petitioner stated that every day is different. She now runs a mold and some of them involve just pushing buttons. Petitioner indicated that on some presses the material is being fed automatically and on some presses she has to put the material in the press and pull the heavy mold in and out and press buttons simultaneously to close the press; those buttons are above her head. Petitioner stated that after doing that a few hours she starts feeling like a pulling sensation in her left shoulder. Petitioner stated that vacuuming is not as easy as it used to be, her arm tires faster. She cannot sleep on her left side as it wakes her in pain. Cleaning things above her head is not easy as before; she has to do it in small doses. She cannot do full spring cleaning as she is left handed and wiping and things gets her arm sore. She has a hard time doing dishes with heavier items and putting them into cabinets overhead. She does take Ibuprofen-(OTC) at least twice per day. She usually takes it about half way through the work day and then before bed.

- Ms. Folmer, who testified for Respondent, stated she had worked for Respondent for 34 years. She is safety manager and currently also trains ergonomics in all related to compliance with OSHA mandated training. Ms. Folmer testified that she is familiar with the work stations Petitioner had described. She knew Petitioner was working at the stations; job title assembler. She stated that entails employees assembling components that weigh from an ounce to 5 pounds. She indicated they work in a U-shape cell and materials are passed left to right depending on the work station. She stated there are multiple products and different types of recessed cans; residential to commercial. She testified it was consistent with Petitioner's description of her job processing the cans. She was familiar with station one applying the labels. She stated there was no work at that station above shoulder level. They pull the labels to affix them on the cans. She indicated labels may be about waist high. All tables are about waist level and labels are about 6 inches over the table. She testified that there was no reason to reach above Petitioner's shoulder level. They would peal 2 stickers and put them on. There was no activity at that station with pneumatic devices other than foot pedal. She testified there was no activity at station 1 that was with the arms above shoulder level. Ms. Folmer was shown picture exhibits and noted the air gun for inserting the screws and the conduit for inserting into the frame with the air gun use. She indicated the air gun was suspended and was about a pound. She agreed with Petitioner's description regarding station 5, with the frames and the angled gun. She indicated photo showed a work station Petitioner could have worked at using the screw air gun. She indicated all screw guns are situated about 1-2 inches above the actual units they work with, so there was no reason to reach over the shoulders. She indicated the employees

can alternate, sitting/standing. She agreed the person in the photo was holding the screw gun in her hand; suspended as described. She indicated when the gun is released it returns to 1-2 inches above; about stomach high. She indicated the most they would have to reach was 12-16 inches. She stated they train employees to make sure they are in the safety zone, about waist level, and not to go past shoulder or sides. She agreed # 3 showed a lady holding the gun at station 5 as Petitioner described. She stated that air gun was different due to the different applications throughout the cells. She stated they do not want the employees twisting or inserting sideways, twisting their wrists. She stated that was an L-shaped gun. She indicated there was like a lazy-Susan for the finish applications to rotate the can and avoid twisting the wrists. Picture 4 was of a tool, on the coil as suspended, at the station to put on bracket. They would tap on the hander bar. She testified at those stations there was no reason to work over or above shoulder height.

- Ms. Folmer indicated the ergonomic standpoint of rotation or work breaks. She stated 2nd shift was somewhat new to them so they started with heavy training. As all employees were new they had to be acquainted with the program ergonomics, safety expected of them. She stated they start with a 7-minute stretch program and then a 10 minute FYI session. She indicated they take a 10-minute break after 2 hours and a half hour lunch. She did not know of a reason Petitioner would be at a station for 6 hours. As they train to rotate people every 2 hours. She indicated they did not want the same employee staying in the same station-(cell); they want them acquainted with the different products. It may be a different product depending on the work day. She stated rotation was not optional it was the program. If it was critical they would have to ask if they could go beyond the 2 hours. Ms. Folmer indicated the tasks at stations 1, 3, & 5 were table top assembly work never going higher than shoulder. She stated all stations are set up by an ergonomic specialist who evaluates each station and defined the need to rotate and lifting techniques and things being performed, avoiding forceful movements, etc. She indicated no reason to reach up through the day for the screw gun. She stated they encourage employees to report unsafe things. She stated an ergo specialist does pre-set up and they can go and evaluate a task to see jhow it is performed. Ms. Folmer further indicated the screw driver is hanging from a support bar structure and on a coil for when the person is not holding it. There are different set ups for different air guns, different weights. It does not roll back up, it is pulled from 4-6 inches above the table. Ms. Folmer was not subpoenaed to testify; her salary did not depend on it. She agreed she had been asked to take photos in RX 3. She indicated it was the same condition to her knowledge.

The Commission finds that Petitioner's and Respondent's testimony differ as to whether there were any overhead/over shoulder work activities. Both agreed they would do about 100 pieces per hour at each station. The Arbitrator observed both and found Petitioner more credible and persuasive. Respondent's witness took pictures of the different stations but did not know what product Petitioner had worked on. Petitioner testified of performing those work duties and developing the left arm/shoulder symptoms and medical records documented to support that testimony even as to the repetitive nature of the work and overhead/over shoulder activities noting Petitioner being of short stature at 5'2" so clearly reaching up and over more that taller. The photos showed the screw gun only in use so there is no way to know the location while hanging other than

Petitioner's testimony that rebutted Respondent's witness testimony it was inches above the cans; Respondent's witness does not appear credible on that point as there are different sizes and clearly, they would not want to be hitting and damaging the cans while moving them repetitively across to do the task on the cans if the screw gun was too low. There were different things to be done on each can in the different stations and working up to 100 cans per hour at each station. There was rotation to different stations every 2 hours, but Petitioner testified of staying a lot at the one station as she was faster, so she had less variation of tasks. Petitioner reported the problem and went to Alexian who documented the symptoms developing with the repetitive work activities; there was notice provided, that testimony is not rebutted. While there was no heavy lifting, there is testimony and evidence of the repetitive nature of the tasks and the development of symptoms manifesting (DX) 10/2/15 to find Petitioner met the burden of proving accident that arose out of and in the course of employment (via repetitive trauma). Likewise, records noted the repetitive nature of the activities and symptom development to support that Petitioner met the burden of proving a causal connection between the activities (not just normal activities of daily living). 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, and affirms and adopts the Arbitrator's finding as to causal connection-(CC).

The Commission finds that Respondent did not address the issue of 'notice' in their Statement, it is therefore deemed as waived. Regardless, Petitioner's testimony of notice was not rebutted and Respondent did direct Petitioner to Alexian at that time. Petitioner stated the Arbitrator properly found timely notice; unrebutted Petitioner testimony supported notice. The Commission, herein, affirms and adopts the Arbitrator's finding of notice.

The Commission, as to the issue of temporary total disability finds, with the evidence of the authorization off work or restrictions, that Respondent did not accommodate, to find Petitioner met the burden of proving entitlement to the 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 total temporary disability, Correcting only as to clerical error as to period 10/23/15—6/2/16 in order.

The Commission finds, as to issue of medical expenses, Section 8(j) credit/hold harmless, with finding above of accident/causal connection/notice finds evidence of the bills and medical records and surgery (Respondent's Section 12 examiner found the care reasonable and necessary even though he found no CC) to find Petitioner met the burden of proving entitlement to the benefits as awarded. Respondent did not address the issue of credit/hold harmless, it is therefore deemed as waived. Regardless, Respondent to hold harmless for any and all claims of providers for which Respondent is receiving the credit. 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/OTHER-credit/hold harmless.

The Commission finds, as to the issue of permanent partial disability, that with finding above of accident/causal connection/notice finds evidence of the treatment and testimony of ongoing condition of ill-being to find Petitioner met the burden of proving entitlement to the permanent partial disability-(PPD) benefits as awarded given the surgery and fairly good recovery. 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 Permanent partial disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 25, 2017 is hereby affirmed and adopted, except for correction of clerical error.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $222.06 per week for a period of 32 weeks-(October 23, 2015 through June 2, 2016)-(total TTD=$7,105.92; Respondent paid $1,554.42 in TTD), 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 62.5 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 12.5% loss of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $9,303.02 for medical expenses-(various providers, expenses still outstanding, as noted in the Arbitrator's decision) under §8(a) of the Act. Respondent shall be given a credit of $41,409.40 for medical benefits paid and Respondent shall hold petitioner harmless from any claims by any providers of services for which Respondent is receiving credit under Section 8(j).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 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.

18IWCC0382

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $28,700.00. 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:
o-4/19/18
DLG/jsf
045

JUN 14 2018

David Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

ROLLINSON, KAREN
Employee/Petitioner

Case# **16WC000373**

JUNO LIGHTING GROUP
Employer/Respondent

18IWCC0382

On 7/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% 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:

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

1872 SPIEGEL & CAHILL PC
PHILLIP JOHNSON
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

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

Karen Rollinson
Employee/Petitioner

v.

Juno Lighting Group
Employer/Respondent

Case # 16 WC 00373

Consolidated cases: _____

18IWCC0382

An *Application for Adjustment 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 June 19, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0382

FINDINGS

On **October 2, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**17,320.16**; the average weekly wage was $**333.08**.

On the date of accident, Petitioner was **45** 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 $**1,554.42** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**1,544.42**.

Respondent is entitled to a credit of $**41,409.40** under Section 8(j) of the Act.

ORDER

- Respondent shall pay Petitioner temporary total disability benefits of $**222.06**/week for **32** weeks, commencing **10/23/2015** through **6/2/2017**, as provided in Section 8(b) of the Act.
- The Respondent shall pay directly to the Petitioner, unpaid medical expenses in the amount of $**9,303.02**, pursuant to the Illinois Medical Fee Schedule as provided in Sections 8(a) and 8.2 of the Act as follows $1,182.00 for ABMG Immediate Care; $6,232.00 for Alexian Brothers Medical Center; $1,582.14 for Holy Family Medical Center; and $306.88 for Loyola University Health System.
- Respondent shall be given a credit of $**41,409.40** 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 $**220.00**/week for **62.5** weeks, because the injuries sustained caused the **12.5%** 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.

18IWCC0382

FINDINGS OF FACT

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) medical bills; 5) temporary total disability; and the nature and extent of Petitioner's injury. *See,* Ax1.

Petitioner's Testimony

Karen Rollinson, (the "Petitioner") testified that she began working at Juno Lighting Group in May 2015, as an assembly line operator assembling recessed can lights. She worked the newly created second shift, Monday through Friday from 4 pm until 12:30 am (Tr.10-11). She testified that the assembly line consisted of 8 or 9 stations in a cell and that she was supposed to work different stations, but would always get moved back to the same station (Tr.12). Petitioner testified and the medical records confirm that she is 5 foot 2 inches tall (Tr.61).

She described station number 1, where stickers would be placed onto the recessed can. The stickers were on a cart next to her and on a bar over her head. In relation to where she stood at this workstation, the roll of stickers would be to her right and above her head. She testified that she is left-hand dominant and she would place two stickers on each can and would process between 90 and 100 cans per hour. She would spend 1 to 2 hours at this station depending on production (Tr.13-14). She would use her left arm to reach to her right above eye-level, to peel the sticker from its backing and place it on the can (Tr.15). At this station, there was also a rivet placed into the can, which was operated by a foot pedal. The can would then move on to station number 2 (Tr.16). On cross-examination, Petitioner testified that she would grab the cans from her right and place them on the table at stomach level, then reach above shoulder level to pull a sticker off the roll (Tr.58-59).

At station 2, a lid would be placed on the can and held in place by a rivet operated by a foot pedal (Tr.16). Petitioner testified that she never worked at station 2 (Tr.17).

At station number 3, a "Made in the USA" sticker was placed on the can. She would reach forward to approximately shoulder level in front of her, grab the sticker to place on the can; then use a screw gun to insert a screw (Tr.17-18). The screw gun was suspended on a coil above her head and was positioned at approximately eye level. She would reach forward, pull the screw gun down, put in the screw, then send the can to the next station (Tr.19). Again, she testified that she would process between 90 and 100 cans in an hour (Tr.20).

Upon cross-examination, she testified that she stood at station 3 to operate the pneumatic screw gun. The work table was at stomach height and she would reach up to get the screw gun, which was above her head (Tr.60-61). She testified that the base of the gun was positioned higher than 5 feet 2 inches (Tr.61). The screw gun was attached to a flexible coil which springs back up above her head when released; and she would reach above her head somewhere between 90 and 100 times to get the gun, bring it down to put in one screw and then release it (Tr.62-63).

At station number 4, she would secure four parts to the inside of the can using a rivet gun operated by a foot pedal. She did not work at this station very often (Tr.20-21).

At station number 5, the cans would be stacked on the workstation table. Petitioner testified that she placed the can into a mold so that the can did not move, then added a rectangular metal frame and used a screw gun to secure it with 3 screws (Tr.21). The screw gun was about 13 or 14 inches long with an L-shaped drill head and was suspended directly in front of her, above eye level. The head of the drill would face to the petitioner's left because it was set up for right-handed people (Tr.22-23). She stated that it was easy when inserting the screw on the left. To insert the screw in the front and on the right, she would have to twist the screw gun to make the head fit where it needed to go. She testified that the position of her left arm was bent and her left elbow was pointed towards the ceiling at approximately shoulder level. Once the part had been secured, the can was then flipped and a conduit was inserted (Tr.23-24). A clip to secure the conduit was then placed in position at approximately stomach level. Petitioner testified that she would process 90-100 cans in an hour at this station (Tr.25).
At station number 6, yellow plastic pieces for the insertion of wires were placed onto the can fixture. A sticker was placed onto the can and it moved to the next station. The work at this station was done at waist level and Petitioner testified that she did not work at this station very often (Tr.26). On cross-examination, Petitioner again testified that the can was placed into a mold and while standing; the screw gun was above her head. She would reach up to get the gun, then bring it down to fasten the base plate onto the can (Tr.64). She would reach for the screw gun once to insert three (3) screws, holding the gun with her left hand; using her right hand to place a screw into the gun (Tr.65-66). She testified that she would do this with 90-100 cans in an hour.

At station number 7, she testified that the can was placed in a mold and aluminum bars were attached to the fixture and were "smacked on" with paddles. Another screw was inserted with a screw gun that she pulled from a position above her head. She would process between 90 and 100 cans per hour at this station. The cans would then be packed at station number 8, a task which she never performed (Tr.27).
Petitioner testified that every 2 hours, she would rotate through the stations and if she was on a different station and somebody was backed up on station 5, she would be moved back to station 5 so the line could catch up. She testified that in the beginning of September, she spent most of her time at station 5 and could spend up to 6 hours per day at that station (Tr.28). The people on the lines always changed and she would end up back at station 5 because other people were slow and couldn't keep up. Further, while she remained at station 5, the other employees would still rotate to other stations (Tr.29).

On cross-examination, she testified that the primary stations that she worked at were 1, 3 and 5 (Tr.56). She further testified that it was possible that as she moved from station to station, she would work on the same piece (Tr.57).

Petitioner began noticing pain in her left arm during the second week in September, while pulling down the screw gun and twisting her left arm to insert the screws. She testified that on October 2, 2015, she reported to her supervisor, Gustavo and her lead operator Christian, that she was having symptoms in her left arm (Tr.29-30). She initially sought medical treatment at an Immediate Care Center affiliated with Alexian Brothers Medical Group on October 2, 2015 (Tr.31). The week leading up to the injury, Petitioner work 32 hours. The 2 weeks prior to that, she worked 40 hour weeks from September 13, 2015 through September 25, 2015 (Tr.82). This was supported by Petitioner's wage statement containing her earning records (RX4).

She continued to work her regular job despite work restrictions (Tr.33) until October 22, 2015, when she was placed on modified duty work, which included no work above shoulder level. She testified that the respondent could no longer accommodate her restrictions and she began losing time from work on October 23, 2015 (Tr.34-35).

Upon cross-examination, she testified that she received weekly compensation benefits from October 16 to December 4, 2015, and was not paid after that date (Tr.68).

Petitioner testified that she received a phone call from Marta in Respondent's Human Resource Department on June 3, 2016 to inform her that she could return to work in a light duty capacity, as they could now accommodate her restrictions (Tr.41). Petitioner testified that she was offered a better job which was not as physical and informed Respondent that she would not be returning because she had found employment that suited her health needs (Tr.42).

Petitioner testified that prior to working for Respondent, she worked at Northwest Fliers as an airline detailer for 1 year (Tr.42). Her job duties included vacuuming private planes, restocking planes and wiping down windows and that none of these activities involved overhead work (Tr.43). On cross-examination, she testified that she stopped working for Respondent in November 2014 (Tr.49) and from November 2014 until May 2015 she was unemployed (Tr.50-51).

Petitioner testified that prior to September and October 2015 she never had any problems, injuries or medical treatment for her left shoulder (Tr.43).

Petitioner is currently employed at Saint-Gobain as an injection mold operator. She began working for this employer in October 2016 and works 40 hours per week Friday through Tuesday, 6:30 AM to 3 PM and earns $14.71 per hour (Tr.44). Her job activities involve running a mold press of which some of them operate by a push button. When operating a transfer press, she must put the material into the press which involves pulling a heavy mold in and out. When starting the press, she has to push two buttons simultaneously, which are both situated above her head (Tr.45).

She testified that currently, after a few hours at work, she begins to feel a pulling sensation in her left shoulder (Tr.45). Her left arm gets tired easily and she has difficulty vacuuming. She cannot sleep on her left side because she wakes up in pain. She has trouble with over-head activities and must do those activities in small doses. She has trouble putting plates and heavier items away if it involves a movement that is above her head. She takes 1200-1600 mg of ibuprofen at least twice a day and typically takes 600-800 mg halfway through her work day and 600-800 mg before bed (Tr.46-47). She testified that Dr. Tonino suggested the over-the-counter medication and was aware that Petitioner was taking between 1200 and 1600 mg of ibuprofen per day (Tr.73-74).

Upon cross-examination, Petitioner testified that during her first week of employment with Respondent, she worked 24 hours between May 17 and May 22, which was the orientation period (Tr.51). She admitted that there were weeks where she did not work a full 40 hours (Tr.55).

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Respondent's Witness's Testimony

Ms. Lileana Folmar testified on behalf of the respondent. She has been employed by Respondent for thirty-four (34) years and was the safety manager for the last eight (8) years (Tr.88, 115). She is familiar the work stations as described by the petitioner and confirmed that Petitioner worked at those stations as an assembler (Tr.88-89). Ms. Folmar testified that she heard the petitioner's testimony about the processing of certain cans, which was consistent with her job description (Tr.90). Ms. Folmar testified that she might be familiar with work stations 1, 3 and 5, if she knew the product numbers (Tr.90). She also testified that the first station did not involve any work above shoulder level and that the rolls of labels are situated approximately 6 inches above the table, which stands at waist height (Tr.91-94).

Respondent offered into evidence as Respondent's group exhibit 3, five (5) black-and-white photographs of purported workstations, taken by Ms. Folmar. She testified that picture 1 of exhibit 3 depicted a pneumatic air gun which employees used to insert all types of screws (Tr.95 and RX3 p.1). Page 2 shows the conduit and plaster frame that employees insert by utilizing the pneumatic air gun which is suspended (RX3 p.2). Ms. Folmar testified that this exhibit would be equivalent to what Petitioner testified as being station 5, where she would put on the square panel with the screws (Tr.96). She also testified that page 3 was a picture described by Petitioner as station 5, where the plaster frame is inserted into the can with the horizontal drill or angle gun (Tr.96 and RX3 p.3). Ms. Folmar testified that this picture was what Petitioner testified to as station 5 (Tr.96). Ms. Folmar testified that page 4 is another type of air gun which could be used to insert a rivet (Tr.97 and RX3 p.4) and depicts the coil which suspends the unit (Tr.103).

Ms. Folmar testified that page 5 was the area where the hanger bars are inserted into a fixture and tapped into place (Tr.97,103 and RX3 p.5).

Ms. Folmar testified that page 1 of exhibit 3, containing the image of an employee holding the pneumatic screwdriver, would have been a station where the petitioner used such a tool (Tr.97 and RX3 p.1). She testified that all their air guns are set up to hang 1 to 2 inches above the actual unit that the employee is working with. Once released, this screwdriver gun would hang anywhere from 1 to 2 inches above the work product and that there would be no reason for any employee to reach above shoulder level (Tr.98-99).

Ms. Folmar testified that page 2 of exhibit 3 is a picture of an employee working with conduit and that this was the station where the square piece was fastened on top of the can and the conduit inserted (Tr.99). The employee is holding the screw gun in her right hand and it would coil back to 1 or 2 inches in front of the employee; and that they would only have to reach forward about 12-16 inches to grab the screw gun (Tr.100-101).

She testified that image 3 was consistent with what Petitioner described as the work activities at station 5 (Tr.101). She explained that this air gun is different because the screws had to be inserted sideways and they didn't want employees twisting their wrists. This gun was L-shaped to make it unnecessary to have to reach inside the can to insert the screw (Tr.102). Ms. Folmar testified that when they finish one application "it is like a lazy susan" and it rotated to the next application to avoid twisting the wrist (Tr.102). On cross-examination, she testified that she did not take a picture of the

lazy susan apparatus and that it could not be seen in the picture. She testified that the screw guns could be set up for right or left-handed employees because there was a clip that would disconnect and reattach the screw gun; and that the set-up would be performed by the group leader (Tr.130-131).

Ms. Folmar testified that at stations 1, 3 or 5, there was no reason that Petitioner would do any activities over or above shoulder height (Tr.104). She further testified that the second shift was newly created and they started new employees with heavy training so that they were acquainted with the whole program of ergonomics, safety and what was expected. The first seven (7) minutes of the shift was a stretching program in which new employees were trained during orientation. The shift started at 4 pm and after 2 hours they would take a 10-minute break. They would then have a half-hour lunch and another 10-minute break. Ms. Folmar testified that she was not aware of a situation where Petitioner would work for 6 hours straight at any station and that the rotation program of every 2 hours, was not optional. She testified that all workstations were set up by an ergonomic specialist, who defined how often people needed to rotate, the type of stretching program to be in place; and training on proper lifting techniques (Tr.105-108).

Ms. Folmar testified that the pneumatic screwdriver hangs from a bar and is supported by the coil which is like a spring. Each coil is set up per the weight of each 1 pound air gun and that it would hold that one-pound without dropping completely. When released, it does not roll back up (Tr.110). On cross-examination, she agreed that it was her testimony that the screw guns were positioned 1-2 inches above where the employee was performing their work. She further testified that the screw gun was attached to a coil that would recoil the screw gun to the original position, if the employee was not pulling it (Tr.127). When addressing picture number 2 of Respondent's exhibit number 3, she testified that the height of the air gun was adjustable and that the employee in this picture was holding the screw gun in her right hand, slightly below shoulder level; and when the employee would release the screw gun, it would recoil to its original position, which was set by the employee (Tr.129).

Ms. Folmar testified that the labels that Petitioner referred to were set up on a spring so that if she pulled them down, the labels were about 4-6 inches above the table. She further testified that they were not on anything that would cause them to roll back up (Tr.110).

She stated that prior to the hearing, she was asked to provide images of the workstations by Respondent's counsel (Tr.112). She testified that Respondent's counsel contacted her 5 or 10 days before the trial and requested that she take the pictures that are contained in Respondent's exhibit 3. She testified that she personally took the pictures of the workstations randomly 5 or 6 days before trial and that Respondent's counsel had asked for pictures of specific workstations (Tr.116). She could not remember the date on which the pictures were taken, only that they were taken a week before trial. She could not state for certain that picture number 2 of Respondent's exhibit 3 was the same as it was in 2015 (Tr.119-120).

She testified that Respondent's attorney asked for the photographs to be utilized for trial and that she knew that Petitioner had worked in department 200; and those are the areas of which she took photographs (Tr.122). Ms. Folmar agreed that every picture contained in Respondent's exhibit 3 contained a depiction of an employee holding the tool in question, but none of the pictures showed the starting position of the screw gun and acknowledged that she could have taken pictures of the positioning of the tool before the employee grabbed it to do the task, but didn't (Tr.141-142).

Upon cross-examination, Ms. Folmar testified that she personally put together the 5-day orientation program which is done with the assistance of security personnel (Tr.113-114). She testified that for the past 8 years, the Respondent had employed an ergonomist from a company called Ergonomics Plus by the name of Jill Ramirez, who reassesses the workstations every time there is a change or if there is a new product (Tr.114-115). She testified that the group leader would set up the position of the guns and that whatever position the group leader set the air guns, would be the position that the employee had to use that air gun for the shift. The employees would be able to adjust the height of the air guns (Tr.142).

She testified that the position of the roll of labels at station 1 was presently 6 inches off the height of the desk and that it was in the same position in September or October 2015 (Tr.121). Ms. Folmar testified that she did not take any pictures of the positioning of the roll of stickers at station 1, but she could have done so (Tr.122).

She stated that it is the respondent's policy to minimize overreaching for every workstation, depending on the tasks performed. She testified, "If you are in the assembly line, we minimize it. We try to minimize it to zero." Ms. Folmar testified that a typical employee would process 100 pieces per hour, and when asked whether Petitioner's testimony, that she processed between 90-100 cans in an hour was a fair statement, Ms. Folmar answered "yes and no" (Tr.124). She testified that they did a 5-day orientation for the first week, followed by a 5-day hands-on-training the following week, for the newly created second shift personnel. The entire second shift project was ended in November 2016 (Tr.123-126).

Petitioner's Rebuttal Testimony

Upon rebuttal, the petitioner testified that she only went through a 3-day orientation period during the week of May 17 through May 22, 2015; and that it was taught, for the most part, by security guards. The wage statement indicates that she was paid 24 hours (3 days) during this week (RX4). The following week she worked 40 hours and received on-the-job training by co-workers who had been there for a week or two before her (Tr.147). Petitioner testified that she never met with an ergonomist, Ms. Folmar or any team leader to discuss the design of her workstation (Tr.148); and she disputed Ms. Folmar's explanation that the air gun at stations 1 and 5 were suspended an inch or two above the level where she would perform her work.

Petitioner testified that she never performed the work that was depicted in RX3 p.1, which was a work station that was not in her cell. RX3 p.2, which depicts a woman sitting and holding the screw gun also was not a workstation in her cell. Petitioner testified that RX3 p.3 was an accurate depiction of station 5 and further explained that the can sat on the poles and that there was no "lazy susan" to help maneuver the can while assembling it. She testified that it was stationary and did not move or spin around. She further testified that the screw gun she used did not have a connection so that the gun could be rotated (Tr.149-151). She also clarified her previous testimony that she did not work at a station for 6 hours straight without a break. She would start off at the station, take a break and then in 2 hours, when the other people rotated, she would remain at the same position; and she would return to the same position after her lunch break. When questioned by Respondent's attorney regarding the workstation depicted in RX3 p.1, she again stated that she had never worked at that station but she did recognize that type of gun (Tr.158).

Medical Evidence

On October 2, 2015, Petitioner was seen at Alexian Brothers Medical Group (hereafter "ABMG") with complaints of left, upper arm pain for the last week. She noted that she is left-handed and she works on an assembly line. "She denied any direct trauma to the area and no neck pain. She had no history of the same complaints in the past. The pain is achy and worse with movement; she has continued to work but notes that work is painful. There is no heavy lifting at work only repetition. It is noted that the patient does not work out daily but she does do stretching at work". Musculoskeletal exam showed normal tone and motor strength with no bony abnormalities. Left upper extremity showed no signs of trauma. There was local, reproducible tenderness noted over the belly of the triceps region and no other tenderness noted. Assessment was a muscle strain, specifically of the triceps brachii muscle and she was advised to apply ice and heat locally, and prescribed Naprosyn with food. She followed-up with Dr. James at ABMG on October 5, 2015 for left arm pain which is more severe; Naprosyn did not help. Review of musculoskeletal systems indicated muscle aches and arthralgia/joint pain. Musculoskeletal examination showed tenderness of left triceps and deltoid and neurological evaluation revealed diminished reflexes of the left triceps; she was prescribed Norco (PX1 pp.3-9).

On October 15, 2015, she was seen at Alexian Brothers Medical Center by Dr. Ben vonFischer, complaining of left arm pain for the past 2 weeks (PX2 p.5). The pain was between her elbow and shoulder and progressively worsening. She had been seen by immediate care twice in the past 2 weeks and was given prescriptions for Norco and Naprosyn. She denied having a specific injury or trauma (PX2 pp.6-10). Petitioner gave a history of doing daily repetitive movement at work. She reported that her work required a specific motion to be done repeatedly and noted that usually workers are supposed to switch every 2 hours, but she had been working for extended periods, well over 2 hours (up to 6 hours at a time) as no one could cover her. She reported having to leave work early this day due to worsening left arm pain. The diagnosis was strain of muscle, fascia, or tendon at the left shoulder or upper arm level. She was treated for pain and discharged from care and told to follow-up with an occupational health clinic. She was given work restrictions of limited lifting, carrying, pushing and pulling and to limit gripping and grasping, pinching or reaching above shoulder level with the left upper extremity (PX2 p.20).

On October 17, 2015, she followed-up with ABMG and a report of the initial visit was sent to Respondent containing the history of a 45-year-old female who works on the assembly line and started developing pain in the left shoulder, three (3) weeks prior to her visit. She had no previous injuries to her shoulder. She had been in previous clinics including the immediate care clinic. She was seen twice and then seen in the emergency room 2 days ago. Upon examination, there was tenderness over the trapezius and deltoid with tenderness in the anterior aspect of the left shoulder. She had limited range of motion and external rotation. She was prescribed physical therapy, Naprosyn and Norco as needed. Work restrictions were to avoid strong gripping and limit repetitive motion of the left hand; no lifting more than ten (10) pounds over her shoulders with her left arm and no pushing or pulling more than 10 pounds (PX1 p.10-12). The medical provider noted that this was an injury that occurred at work.

October 22, 2015, she was seen at ABMG with complaints of left shoulder pain made worse by pinching and grasping objects. She had pain in the upper arm radiating into the elbow; she denied any numbness or tingling in arm or fingertips. She was taking Naprosyn and Norco and was still in pain because she is pinching and grasping at work; and after 2 hours working, her pain worsened. She was released to modified duty work with no lifting, carrying, pushing or pulling more than ten (10) pounds and was advised to limit gripping and grasping or pinching with the left upper extremity and no above

shoulder level work. On October 23, 2015, she followed-up at ABMG for left shoulder pain, which was feeling worse than the last visit. She followed-up at Elk Grove and was given the same restrictions but could not do the job. She was released to modified work duty, with no use of the left arm. The diagnosis was a strain of muscle fascia or tendon at left shoulder or upper arm level (PX1 pp. 18, 21, 23-25, 27).

On October 29, 2015, she followed-up at ABMG for left arm pain which was worse after she worked for 2 hours. She went to the Palatine Clinic on 10/24/15 and was off work since. The occupational therapy order from the ER was not accepted. She was given a referral for occupational therapy and advised to use ibuprofen as directed. She was released to return to work with no use of the left upper extremity (PX1 pp. 28-30).

On November 5, 2015, she was seen at ABMG for left shoulder pain which had intensified and she complained of severe pain with elevation. She was released to modified work duty with no use of the left arm. On November 18, 2015, at ABMG it was noted that there was no improvement since the date of injury. She was still in need of therapy but it had not been approved. She was to return to work with no use of the left upper extremity and the diagnosis was impingement syndrome of the left shoulder (PX1 pp. 33-42).

On November 25, 2015, she was seen at ABMG for left shoulder pain. She complained of pain when elevating her left arm with radiating pain to the left shoulder into the left biceps. She had limited range of motion and physical therapy had not been approved. It was noted that the patient had a prolonged recovery and needed physical therapy and likely should get an MRI. She was released to modified duty work no lifting, carrying, pushing or pulling more than ten (10) pounds and no above shoulder level work (PX1 pp. 44-47).

On December 2, 2015, she was seen at ABMG for left shoulder pain with worsened pain with using the shoulder. She could not sleep due to pain and stress. Physical therapy was recommended again (PX1 pp.51-56). She could return to work with no use of the left upper extremity and she was to start physical therapy. On December 16, 2015, she followed-up at ABMG and Dr. James recommended an MRI, which was pending approval. She was released to modified work duty of no lifting, carrying, pushing or pulling more than ten (10) pounds and no above shoulder level work. She attended physical therapy on December 7, 9, 14, 16, 21 and 23 (Px.1 pp. 57, 60-61).

On December 23, 2015, she followed-up at ABMG reporting tingling in the fingers and noted that therapy was not helping. Dr. James' diagnosis was impingement syndrome and he opined that it would be very helpful in determining the etiology of symptoms in light of failed therapy and continued pain. She was released to modified work duty with no lifting, carrying, pushing or pulling more than 10 pounds and no above shoulder level work (PX1 pp.62-66).

On January 6, 2016, she followed-up with Dr. James who noted that she was not getting better. She continued to have pain in the left shoulder with elevation and adduction. He noted that the MRI request was denied and her claim was being disputed. He opined that she needed an MRI of the left shoulder and recommended she follow-up with her primary care physician for an MRI and orthopedic specialist for continued care. She could return to modified work duty of no lifting, carrying, pushing or pulling more than ten (10) pounds and no above shoulder level work (PX1 pp.67-70).

On January 13, 2016, Dr. James released her to light duty work with no lifting, carrying, pushing or pulling more than 10 pounds with the left arm and to limited repetitive motion with left arm; and no

reaching above her shoulder, with the left arm. The diagnosis was impingement syndrome of the left shoulder.

On February 1, 2016, an MRI of the left shoulder was done due to chronic left shoulder pain. The MRI showed mild tendinosis of the anterior distal supraspinatus tendon with irregularity of the bursal surface, which was consistent with mild tendinosis. There was also mild tendinosis of the infraspinatus tendon (PX4). On February 3, 2016, Dr. James applied the same restrictions and she was referred for further care by her own physician (PX1 pp. 72-73).

Petitioner testified that she found Dr. Tonino on the internet (Tr.39) and was evaluated by him on February 11 2015. The diagnosis was left shoulder pain and disorder of bursae and tendons in the left shoulder region. Dr. Tonino ordered physical therapy to evaluate and treat with modalities as needed, twice a week for 3 weeks and she should be released with a comprehensive home exercise program in 3 weeks. X-rays of the left shoulder were normal and she received and cortisone injection into the left shoulder and was prescribed Tylenol and Norco. The intakes sheets from this date of service indicate that she had a left arm injury at work (PX4 pp. 2-7).

On March 16, 2016, Dr. Tonino performed arthroscopic surgery at Gottlieb Memorial Hospital. The petitioner underwent a left shoulder arthroscopy with arthroscopic debridement of partial rotator cuff tear, labral tear and a biceps tenotomy. He also performed an arthroscopic subacromial decompression and a mini open-biceps tenodesis of the left shoulder. The postoperative diagnosis was a partial rotator cuff tear, a partial biceps tendon tear and a degenerative superior labral tear of the left shoulder (PX5 pp.22-23).

She followed-up postoperatively with Dr. Tonino on March 18, 2016 and was having difficulty controlling her pain. Her wounds were clean and dry with no signs of infection. She was advised to continue use of the sling and prescribed Norco as needed; and advised to follow-up in 2-3 weeks (PX4 p.11). She followed- up on April 21, 2016; "status post left shoulder arthroscopy with biceps tenodesis, subacromial decompression, debridement and partial thickness rotator cuff tear". They discussed work restrictions of no lifting more than five (5) pounds and no overhead or repetitive use of the left upper extremity; and continued supervised therapy 3 times a week (PX6 p.3). Petitioner was unable to return to work at this time PX7).

She began a course of postoperative physical therapy at Alexian Brothers Medical Center on April 28, 2016 and underwent the initial physical therapy evaluation. The plan was to begin physical therapy 3 times a week for 6 weeks, for the diagnosis of left shoulder pain status post mini open surgery (PX3 p.13). She was discharged from physical therapy on August 10, 2016, having attended 31 sessions (PX3 p.17).

She then followed-up with Dr. Tonino on May 26, 2016, who ordered continued physical therapy twice a week for 6 weeks and released her to return to work with "no lifting more than 5 pounds and no overhead or repetitive use of the left upper extremity" (PX6 p.9 and PX8).

On July 7, 2016, Dr. Tonino noted that she was doing much better following her left shoulder arthroscopic surgery. "She was 3-1/2 months post-surgery and could elevate to about 160° with pretty good strength on examination". She had minimal discomfort and was to continue physical therapy twice a week for the next 4 weeks with a final follow-up in about 6 weeks (PX6 p.14).

On September 29, 2016, she saw Dr. Tonino for the final visit and was released to go back to work without restrictions and she could resume normal work activities (Tr. 41 and PX9).

On July 13, 2016, Dr. Tonino authored a note summarizing his treatment of the petitioner. He first saw her on February 11, 2015 and she subsequently indicated she was doing repetitive activities at work in October 2015. She was treated with conservative management initially but ultimately she underwent a left shoulder arthroplasty, subacromial decompression, biceps tenodesis and a partial thickness rotator cuff tear. Dr. Tonino asked for a video to determine causation which was not forthcoming. He was given a description of her job which involved an assembly line position for recessed lighting cans. It was his understanding that she spent the majority of her workday at stations 1, 3 and 5. At station 1 she processed 100 cans per hour reaching up with her right and left upper extremity approximately 200 times. Station 3 required working 2 hours per day processing 100 cans and reaching above her shoulder level 400 times.

At station 5, she spent 4-6 hours during the day processing between 100-120 cans per hour; requiring her to reach up and pull down with a screw gun anywhere between 400-720 times. Based on her job description, it was his impression with a reasonable degree of medical certainty that her left shoulder condition and the surgery she required was related to her work activities. She did not have any external injuries or pre-existing conditions that contributed to her condition. It was Dr. Tonino's opinion that based upon a reasonable degree of medical and surgical certainty that the medical treatment provided was causally related because the petitioner's condition was aggravated by or accelerated or exacerbated by the activities she performed at work, based upon the information that he had been provided (PX6 pp.19-20).

On December 2, 2016, she was evaluated by Dr. Baxamusa at the request of the respondent. Dr. Baxamusa noted that he received very brief medical records that included the ER visit at Alexian Brother Medical Center on October 15, 2015, a discharge note from ABMG from October 29, 2016 and records from a November 5, 2015 visit with Dr. James. He noted that she was a 45-year-old, left-hand dominant female assembly line worker, at Juno Lighting. She stated that she worked on an assembly line for approximately 8 hours a day making recessed can lights. She stated that this involved placing stickers on cans, riveting and screwing exercises, using her left upper extremity. Prior to this, he noted her work as an airline detailer for 2 years. Dr. Baxamusa performed a physical evaluation and his diagnosis was left shoulder impingement. He did not identify any specific causative factors within her occupational exposure on the assembly line making can lights to be associated with this impingement syndrome. He opined that there was no causal connection however, she did have impingement syndrome that required additional treatment and further opined that all medical treatment had been reasonable (RX1).

Petitioner testified that during the evaluation she spent approximately ten (10) minutes face time with the doctor. She testified that Dr. Baxamusa did not ask any specific questions about her work activities, he did not inquire about the different positions on the assembly line; he did not ask her about the job rotation and never asked her anything regarding the specific activities that she physically performed on the job (Tr.36-37).

On April 24, 2017, Dr. Baxamusa issued an addendum report to Respondent's attorney. He reviewed his previous IME report and noted that Petitioner was a left-hand dominant female, working on the assembly line from May 20, 2015 to October 20, 2015, with no problems. Petitioner stated that she was normally advised to rotate her position on the assembly line every 2 hours but was left on a job rotation for 4-6 hours and felt the repetitive use caused her left shoulder to hurt. Petitioner reported prior work as an airline detailer for 2 years when her job was terminated. She denied any specific injury. Dr. Baxamusa opined that generally, to have impingement, one would expect overhead

activities such as those of an electrician; or working overhead, placing the shoulder at or away from the body at shoulder level. As the patient, had reported assembly line work with placing stickers on cans and working with the hands below shoulder level, there is no clearly identifiable condition or use that he could identify that would excessively impinge or place the shoulder in an impingement type position. He also correlated a smoking history with rotator cuff health and tendinitis (RX2).

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? and (D) What was the date of accident? The Arbitrator finds the following:

There was disputed testimony at hearing as to the ergonomic set-up of the work stations. Petitioner described stations 1 through 8. Lileana Folmar, on behalf of the Respondent, testified that she was familiar with the work stations described by Petitioner and confirmed that Petitioner worked at those stations as an assembler. Ms. Folmar testified that none of the work stations on the assembly line involved any work at or above shoulder level. She did however agree that a typical employee processed approximately 100 pieces per hour and that employees would rotate the work stations every two (2) hours.

The Arbitrator finds the testimony of Petitioner more credible and persuasive than Respondent's witness. After testifying that she was familiar with the work stations described by Petitioner and confirming that Petitioner worked at those stations as an assembler, she then testified that she might be familiar with work stations 1, 3 and 5 if she knew the product numbers. Later, when asked by Respondent's counsel to take pictures of the work stations, she then testified that she knew that Petitioner worked in Department 200, which indicates that she should have known what products Petitioner worked on. Ms. Folmar took pictures of employees using the tools in question however, did not take pictures of the positions of the tools as they appeared at the work stations without anyone using them, which she could have done. Further, she testified that every employee on the second shift had a five-day orientation when it was clear that Petitioner only had a three-day orientation period as evidenced by her wage statement.

The petitioner testified credibly as to her job activities and her complaints of pain. The Arbitrator notes that the petitioner began working for Respondent in May 2015 as an assembly line operator until October 22, 2015. The assembly line consisted of 8 stations however the primary stations where she worked were stations 1, 3 and 5.

At station 1, stickers were placed on the can. As she stood at the workstation, the roll of stickers was to her right and above her head. Being left-hand dominant and 5 foot 2 inches tall, she used her left arm to reach to her right to peel the sticker from its backing and place it on the can. There was no dispute that Petitioner would process between 90 and 100 cans in an hour. She would spend 1 to 2 hours at this station depending on production. At a minimum, the petitioner would have to reach above shoulder level and across her body to her right 90 times in one hour and could reach above shoulder level up to 200 times.

At station 3, the petitioner would use a screw gun to insert a screw into the can. The screw gun was suspended by a coil at about eye level, which would require her to reach forward and pull the screw gun down to the table. At a minimum, the petitioner would have to reach forward above shoulder level 90

times in one hour and could reach forward and above shoulder level up to 200 times, if she spent two hours at this station.

At station 5, Petitioner would apply 3 screws to secure a rectangular metal frame to the can. The screw gun had an L-shaped drill head and was suspended directly in front of the petitioner at eye level. She could easily insert the screw on the left because she was left-handed and the L-shaped drill bit faced to the left. To insert the screw in the front and right of the can she would have to twist the screw gun to make the head fit where it needed to go, which caused the position of her left arm to be bent with her left elbow pointed towards the ceiling at approximately shoulder level. At a minimum, the petitioner would have to reach forward above shoulder level 90 times in one hour to retrieve the screw gun and manipulate her left arm into a position to screw in two screws at least 90 times. If the petitioner were to spend only one hour at each of the 3 work stations and process 90 cans at each station, she would have to lift her arm to or above shoulder level at least 270 times per day. If she were to rotate through the stations appropriately and spend 2 hours at each station, she would have to lift her arm to or above shoulder level 540 times per day.

Based on the totality of the evidence, the Arbitrator finds that the Petitioner has proven, by a preponderance of the evidence, that she sustained accidental injuries to her left shoulder which arose out of and in the course of her employment as a result of repetitive reaching at or above shoulder level with her dominant arm. The Arbitrator finds that Petitioner was exposed to a risk connected with or incidental to her employment. The act of reaching with her left arm to or above shoulder level a minimum of 270 times per day, the petitioner was exposed to a risk greater than that to which the general public is exposed.

Further, an employee alleging a repetitive trauma has the same burden of proof as an employee alleging a specific injury, that the injury resulted from an identifiable date of injury or manifestation, that is the date on which the injury and its causal relationship to work becomes plainly apparent to a reasonable employee. *Peoria City Bellwood Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). The date may be the date the employee commences medical care, *Three D Discount v. Industrial Comm'n*, 198 Ill.App.3d 43, 556 N.E.2d 261 (1989), the date the employee discontinues working because of the condition, *Oscar Meyer & Co. v. Industrial Comm'n*, 176 Ill.App.3d 607, 531 N.E.2d 174 (1988), or the date a medical provider renders a diagnosis and relates the condition to the employment, *Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 530 N.E.2d 1135 (1988).

In the instant case, the Arbitrator finds that the manifestation date was the date that Petitioner commenced medical care and a diagnosis was rendered and she reported her symptoms to the Respondent. This occurred on October 2, 2015, when Petitioner reported her symptoms of left arm pain to the respondent and was examined at Alexian Brothers Medical Group for left shoulder complaints. She cited a history of working on an assembly line; and that the work involved no heavy lifting, but was repetitive. She was diagnosed with a strain of the triceps brachii muscle of the left upper extremity.

Accordingly, the Arbitrator finds that the petitioner has proven, by a preponderance of the evidence, that she sustained an accidental injury to her left shoulder on October 2, 2015, that arose out of and in the course of her employment with Respondent.

In support of the Arbitrator's Decision relating to (E), Was timely notice given to the Respondent? The Arbitrator finds the following:

As discussed *Supra*, the Arbitrator found that the petitioner sustained accidental injuries that arose out of and in the course of her employment on October 2, 2015.

Petitioner's testimony is unrebutted that she began noticing pain in her left arm during the second week in September while pulling down the screw gun and having to twist her left arm to insert the screws and on October 2, 2015. Her testimony that she told her supervisor, Gustavo and her lead operator, Christian that she was having symptoms in her left arm is also unrebutted.

Consequently, the Arbitrator finds that the petitioner has established, by a preponderance of the evidence, that on October 2, 2015, she gave notice of the accident to the respondent within the limits stated in the Act.

In support of the Arbitrator's Decision relating to (F), Is the Petitioner's current condition of ill-being causally related to the injury? The Arbitrator finds the following:

To obtain compensation under the Act a claimant must show by a preponderance of the evidence that he or she has suffered a disabling injury arising out of and in the course of his employment. *Sisbro, Inc. v. Industrial Comm'n* 207 Ill. 2d 193, 203, 797 N.E. 2d 665, 671 (2003). The arising out of component addresses the causal connection between a work-related injury and the claimant's condition of ill-being. *Sisbro* at 207. A claimant need only prove that some act or phase of his employment was a causative factor in the ensuing injury. *Vogel v. Industrial Comm'n*, 354 Ill.App.3d 780, 821 N.E.2d 807, (2005). A work-related injury need not be the sole or principal causative factor so long as it was "a" causative factor in the resulting condition of ill-being. *Sisbro* at 205.

The Commission has previously held that proof of prior good health and change immediately following and continuing after an injury is sufficient to establish that an impaired condition was due to the injury. While there is no specific opinion of causation contained in the treatment records, such an opinion is not required where the chain of events demonstrates a previous condition of good health, an accident and subsequent injury resulting in the need for medical treatment.

Petitioner testified, in a credible and unrebutted manner, that she never had any problems with her left shoulder prior to September/October 2015. The medical records from ABMG on October 2, 2015 confirm that she had no history of the same complaints in the past. Her symptoms began in late September 2015, which resulted in her seeking medical treatment on October 2, 2015 culminating in surgery by Dr. Tonino on March 16, 2016.

It is the Commission's function, to choose between conflicting medical opinions. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992). Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992).

Dr. Tonino, the treating physician, authored a note dated July 13, 2016, wherein he summarized the petitioner's job activities on her assembly line. He understood that she spent most her work day at stations 1, 3 and 5. At station 1 she processed 100 cans per hour reaching up with her right and left upper extremity approximately 200 times. Station 3 required working at least 2 hours per day processing 100 cans and reaching above her shoulder level 400 times. At Station 5, where she spent 4-

6 hours during the day processing between 100-120 cans per hour, this activity required her to reach up and pull down with a screw gun anywhere between 400-720 times. Based on her job description, it was his opinion, with a reasonable degree of medical certainty, that her left shoulder condition and the surgery she required were related to her work activities. He noted that she did not have any external injuries or pre-existing conditions that contributed to her condition. It was Dr. Tonino's opinion, based upon a reasonable degree of medical and surgical certainty, that the medical treatment provided was causally related and that her condition was aggravated or exacerbated by the activities she performed at work, based upon the information that he had been provided.

Dr. Baxamusa, on the other hand, only noted her work activities on an assembly line involved placing stickers on cans, riveting and screwing using her left upper extremity. He opined that the petitioner did have an impingement syndrome but there was no causal connection between the impingement and her work activities. Petitioner testified that during the evaluation, Dr. Baxamusa did not review her job description or photos, nor did he ask her any specific questions about her work activities. He did not inquire about the different positions she worked on the assembly line and he did not ask her about the job rotation. He never asked about the specific, daily activities that she physically performed on the job. Dr. Baxamusa opined that generally, shoulder impingement would be associated with overhead activities or placing the shoulder at or away from the body at shoulder level. The Arbitrator finds the opinions of Dr. Tonino more persuasive than those of Dr. Baxamusa, as Dr. Tonino was clearly provided more information regarding the petitioner's work activities.

Having found that the petitioner sustained an accidental injury on October 2, 2015, that arose out of and in the course of her employment; and based upon the totality of the evidence, the Arbitrator finds that the Petitioner has established, by a preponderance of the credible evidence, that as a result of her repetitive work activities, she sustained an injury to her left shoulder; and the Arbitrator finds that the Petitioner's condition of ill-being of a left shoulder partial rotator cuff tear, a partial biceps tear and a superior labral degenerative tear of the left shoulder is causally related to the accidental injury sustained by the Petitioner on October 2, 2015.

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

The Arbitrator further finds that the medical treatment and physical therapy that Petitioner received at Alexian Brothers Medical Center and Alexian Brothers Medical Group from October 2, 2015 to February 3, 2016 and again from April 28, 2016 to August 10, 2016; the medical treatment by Dr. Tonino from February 11, 2016 until September 29, 2016 including the arthroscopic surgery at Gottlieb Memorial Hospital on March 16, 2016; as well as the February 1, 2016 MRI at Holy Family Medical Center, is causally related to the petitioner's injury of October 2, 2015.

The dispute as to the respondent's liability for a payment of medical expenses is based upon the disputed issues of accident and causal connection. Based upon the record as a whole including the Petitioner's testimony, Respondent's witness, the exhibits submitted, and consistent with the Arbitrator's findings with respect to accident and causal connection, the Arbitrator finds that the petitioner has established, by a preponderance of the credible evidence, that the following medical bills related to the treatment of the petitioner's left shoulder contained in Petitioner's Exhibit 11 are reasonable, necessary and causally related to the accident of October 2, 2015.

Medical Provider	Date of Service	Charges
1. Alexian Brothers Medical Group	12/9/2015 (PT)	$58.00
2. Alexian Brothers Medical Group	12/23/2015 (Doctor visit)	$163.00
3. Alexian Brothers Medical Group	12/23/2015 (PT)	$268.00
4. Alexian Brothers Medical Group	1/6/2016 (Doctor visit)	$163.00
5. Alexian Brothers Medical Group	1/13/2016 (Doctor visit)	$163.00
6. Alexian Brothers Medical Group	1/20/2016 (Doctor visit)	$204.00
7. Alexian Brothers Medical Group	2/3/2016 (Doctor visit)	$163.00
8. Alexian Brothers Medical Center	5/31/16-6/30/16 (PT)	$1,976.00
9. Alexian Brothers Medical Center	7/5/16-8/1/16 (PT)	$3,496.00
10. Alexian Brothers Medical Center	8/5/16-8/10/16 (PT)	$760.00
11. Holy Family Medical Center	2/1/2016	$1,582.14
12. Loyola University Health System	2/11/16 (Dr. Tonino)	$203.88
13. Loyola University Health System	7/7/16 (Dr. Tonino)	$103.00
		$9,303.02

The Arbitrator therefore finds that the respondent shall pay to the petitioner, the amount of $9,303.02 in the above outlined and unpaid medical expenses pursuant to Section 8(a) of the Act and pursuant to the Illinois Fee Schedule as outlined above.

At hearing, Petitioner introduced into evidence as Petitioner's Exhibit 10 a statement of the Blue Cross Blue Shield subrogation lien, for benefits paid totaling $41,409.40. There was a question as to the accuracy of the medical bill summary which only indicated that group insurance paid $28,140.22. The Arbitrator finds that the medical bill summary did not include a $1,295.62 payment made by Blue Cross Blue Shield to Gottlieb MA LLC for date of service 3/16/2016, nor did the medical bill summary include a $13,046.00 payment by Blue Cross Blue Shield to Loyola University Medical Center for date of service 3/16/2016.

Respondent shall be given a credit of $41,409.40 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 support of the Arbitrator's Decision relating to (K), What temporary benefits is the Petitioner entitled to? The Arbitrator finds the following:

After her initial medical treatment on October 2, 2015, Petitioner continued to work her regular job despite work restrictions. On October 22, 2015, she was seen at ABMG and was placed on modified work duty, which included no work above shoulder level. Petitioner testified that the Respondent could no longer accommodate her restrictions and she began losing time from work on October 23, 2015. This testimony is unrebutted. Petitioner received a phone call from Marta in Respondent's Human Resource Department on June 3, 2016 to inform her that light duty work restrictions could be accommodated. Petitioner elected not to return to work for the respondent.

Petitioner's entitlement to temporary total disability benefits is based upon the disputed issues of accident and causal connection. Having found that the petitioner's injury of October 2, 2015 arose out of and in the course of her employment and that the petitioner's condition of ill-being is causally related to that injury, the Arbitrator finds that the Petitioner has established, by a preponderance of

the credible evidence, that the respondent should pay to the petitioner temporary total disability benefits in the amount of $222.06 per week for 31 weeks for the period of October 23, 2015 through June 2, 2016.

In support of the Arbitrator's Decision relating to (L), What is the nature and extent of the Petitioner's injury? The Arbitrator finds the following:

Pursuant to §8.1b of the Act, for accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria: (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment; (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
(i) the reported level of impairment pursuant to 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 medical records.

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

Regarding (i) of Section 8.1b(b) of the Act, the Arbitrator concludes the following:
The Arbitrator notes that the Illinois Appellate Court in *Corn Belt Energy Corp. v. IWCC*, 2016 IL App (3d) 150311 WC does not impose an obligation on either party to submit an impairment rating. The Arbitrator notes that in this matter, either party submitted an impairment rating. No weight is given this factor.

Regarding (ii) of Section 8.1b(b) of the Act, the Arbitrator concludes the following:
The petitioner's occupation was an assembly line operator. Petitioner did not return to work for Respondent by her own choice to find a job less physically demanding. Petitioner is currently employed as an injection mold operator which involve running a mold press. When operating a transfer press, she must put material into the press which involves pulling the heavy mold in and out and pushing two buttons simultaneously, which are both situated above her head. After a few hours at work she begins to feel a pulling sensation in her left shoulder. The Arbitrator concludes that because of the physical nature of the Petitioner's work in as an injection mold operator, the petitioner's permanent partial disability will be more extensive than an individual who performs less physically demanding work. The Arbitrator gives some weight to this factor.

Regarding (iii) of Section 8.1b(b) of the Act, the Arbitrator concludes the following:
The petitioner was 45 years old at the time of the injury. The Arbitrator considers the petitioner to be a somewhat younger individual and concludes that the Petitioner's permanent partial disability will be more extensive than that of an older individual because she will live with the permanent partial disability longer. The Arbitrator gives some weight to this factor.

Regarding (iv) of Section 8.1b(b) of the Act, the Arbitrator concludes the following:
At the petitioner's current employment, she earns $14.71 per hour and works 40 hours per week. The Arbitrator concludes that the Petitioner's injury does not currently adversely affect the petitioner's earning capacity. The Arbitrator gives no weight to this factor.

Regarding (v) of Section 8.1b(b) of the Act, the Arbitrator concludes the following:
Petitioner cannot sleep on her left side because of pain, she has trouble with overhead activities, her left arm is easily fatigued. She takes 1200-1600 mg of ibuprofen at least twice a day and typically takes 600-800 mg halfway through her work day and 600-800 mg before bed. Dr. Tonino suggested the over-the-counter medication and was aware that Petitioner was taking between 1200 and 1600 mg of ibuprofen per day.

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors stated in the Act. In making this evaluation of permanent partial disability, consideration is not given of any single enumerated factor as the sole determinant. Therefore, applying Section 8.1b of the Act, and having considered and weighed all five factors enumerated by the Act, the Arbitrator finds that the Petitioner has sustained accidental injuries that have caused 12.5% loss of use of the petitioner's whole person. The Arbitrator further finds that the Respondent shall pay the Petitioner the sum of $220.00 per week for 62.5 weeks as provided for in Section 8(d)2 of the Act.

18IWCC0382

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
16WC00373
SIGNATURE PAGE

Signature of Arbitrator

July 25, 2017
Date of Decision

JUL 25 2017

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

Rolland R. Englund,

Petitioner,

vs. NO: 10 WC 16346

Sharkey Transporation Inc.,

Respondent.

18IWCC0383

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 27, 2017, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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 14 2018
o050318
DLG/mw
045

David L. Gore

Stephen Mathis

DISSENT

I respectfully dissent from the Decision of the majority which affirmed and adopted the Decision of the Arbitrator. I would have modified the Decision of the Arbitrator to terminate temporary total disability ("TTD"), as of May 23, 2014, terminate maintenance as of March 23, 2015, and deny vocational rehabilitation services.

Petitioner sustained a work-related injury to his right shoulder/trapezius area on December 7, 2009. He was diagnosed with right brachial plexopathy. He had extensive conservative treatment, including numerous trigger point injections. On January 26, 2011, Petitioner had an examination ("IME") with Dr. Hagman, at Respondent's request pursuant to Section 12 of the Act. Dr. Hagman noted that the lack of muscle atrophy raised issues about Petitioner's possible exaggeration of symptoms.

On May 26, 2011, Petitioner had a Functional Capacity Evaluation ("FCE"). However, the FCE was not considered valid due to early termination and the therapist noted that "analysis of findings suggests some questions should be drawn regarding petitioner's reports of pain and disability. Some formal reliability testing was indicative of poor psychodynamics when relating to illness and pain ratings." On May 23, 2014, Petitioner had another IME with Dr. Konowitz. Dr. Konowitz diagnosed resolved brachial dysesthesias secondary to local trauma, recommended a diagnostic injection to determine the etiology of Petitioner's subjective complaints, and opined that Petitioner could return to work at full duty without restrictions. On March 23, 2015, Petitioner's pain management doctor, Dr. Panozzo, found Petitioner to be at maximum medical improvement, though he noted that Petitioner might need some injections in the future, and released him to work with a permanent 30-pound lifting restriction.

Petitioner testified he began a job search on December 29, 2015, more than nine months after Dr. Panozzo declared him at MMI and released him to work with restrictions. Petitioner testified that his job search involved looking through the telephone book and making calls. He did not make any in-person visits to prospective employers. The record indicates that he made a total of approximately three to five calls a week. I conclude that Petitioner did not conduct a diligent job search. The lack of such a diligent effort, as well as the findings of possible symptom magnification noted by Dr. Hagman and the questions raised in the FCE about his pain and disability complaints, raise serious doubts as to Petitioner's veracity and credibility.

I would have modified the Decision of the Arbitrator to terminate TTD as of May 23, 2014, the date Dr. Konowitz released him to full duty, terminated maintenance as of March 23, 2015, the date Dr. Panozzo declared him at MMI, and denied vocational rehabilitation services because he had not shown satisfactory motivation in finding employment. Therefore, I respectfully dissent from the majority.

DLS/dw
46

Deborah L. Simpson

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

ENGLUND, ROLLAND R
Employee/Petitioner

Case# **10WC016346**

SHARKEY TRANSPORATION INC
Employer/Respondent

18IWCC0383

On 6/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1874 AMES LAW OFFICES
STEVEN C AMES
100 3RD ST PO BOX 55
ORION, IL 61273

5647 ACCIDENT FUND GROUP
PERRY GENTILE
PO BOX 40785
LANSING, MI 48901

STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Rolland R. Englund
Employee/Petitioner

v.

Sharkey Transportation, Inc.
Employer/Respondent

Case # **10** WC **16346**

Consolidated cases: **N/A**

18IWCC0383

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **2/9/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **12/7/09**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,407.84**; the average weekly wage was **$680.92**.

On the date of accident, Petitioner was **48** 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 reasonable and necessary medical services of $47,466.02, as set forth in Petitioner's exhibit 17, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a 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 prospective medical care as recommended by Dr. Panozzo, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $453.95/week for 275 5/7 weeks, commencing 12/8/09 through 3/23/15, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $ for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner maintenance benefits of $453.95/week for 98 3/7 weeks, commencing 3/24/15 through 2/9/17, as provided in Section 8(a) of the Act. Respondent shall be given a credit of $5,142.86 for wages Petitioner earned from Crescent Lake Club.

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

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

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

Michael K. Nowak, Arbitrator

6/19/17
Date

18IWCC0383

FINDINGS OF FACT

Petitioner worked as an over-the-road semi-truck driver for Respondent, Sharkey Transportation, Inc., for about seven years prior to his 12/7/09 accident. His duties included driving a semi, hooking up, and unhooking trailers. He was 48 years of age at the time of accident with a 10th grade education and no GED. He went to truck driving school, and had driven a semi for 20 years. Petitioner testified he never injured his back or right shoulder prior to his employment with Respondent.

On 12/7/09 Petitioner sustained an undisputed accident. He was in the process of connecting a trailer. He attempted to lift a bar connected to the trailer hitch mechanism with his shoulder, causing immediate burning pain six inches down from the base of his neck. The Application for Adjustment of claim reflects that the affected body part was man as a whole and right upper extremity. He immediately contacted his dispatcher.

Respondent's safety department sent Petitioner to a "work doctor," the Galesburg Clinic. They gave him pain pills and a muscle relaxer, taking him off work seven days. (PX 1). In early 2010 he underwent MRI's of the thoracic spine and right shoulder, which were negative. (PX 1). He saw doctor Michael Dolphin giving a history of trying to use a five foot bar to lift a tandem for a trailer trying to engage a pin. He used the bar on the outer part of his right shoulder to get more leverage which brought about sharp pain described throughout the right lateral shoulder, right upper thoracic region around T3-T6, as well as down his right arm which then felt subjectively weak and heavy with use above the level of the shoulder. He had physical therapy which made his pain worse. Dr. Dolphin felt the right-sided neck and arm pain may take several months to heal. He suggested trigger point injections. (PX 2).

Petitioner saw neurologist Michael Cullen who recommended an EMG/NCV, which showed a mild right brachial plexophathy. (PX 3). He was seen at the Illinois Neurological Institute in Peoria, where Dr. Lin had him resume physical therapy. (PX 5).

On 7/3/10 Petitioner saw Dr. Salehi at MLS Medical Evaluation Services at Respondent's request pursuant to section 12 of the Act. Dr. Salehi recommended a supra scapular injection. He was placed on light duty, lifting up to 20 pounds, no push/pulling over 35 pounds. (RX 2). He then underwent a steroid injection through pain Management Associates eon 8/30/10. (PX 8). A repeat EMG/NCS on 9/21/10 was negative. (PX 9).

On 11/3/10 Petitioner underwent a second section 12 examination with Dr. Salehi, who recommended a two week work conditioning program, to be followed with an FCE. (RX 3).

On 1/26/11 Petitioner saw Dr. Hagman for yet another section 12 examination at Respondent's request. Dr. Hagman noted that a clear cut diagnosis was not possible. He recommended an updated EMG focused on suprascapular nerve innervated musculature of the right shoulder and a functional capacity evaluation. Dr. Hagman believed that Petitioner had reached MMI from nonsurgical care and suggested that if the EMG was negative, that Petitioner stop narcotic-type medication and utilize non-steroidal anti-inflammatory medications. Dr. Hagman opined that Petitioner return to work on a medium duty basis, but further suggested an FCE to determine what restrictions were appropriate. (RX 4)

On 5/26/11 Petitioner underwent an FCE at Orthopaedic Rehabilitation Specialists. The therapist indicated that Petitioner's current physical work tolerances were unable to be determined during today's test secondary to early termination of testing due to pain. The early termination of testing by the Petitioner made it impossible to recommend appropriate restrictions. (PX 13). Following the receipt of the report regarding the FCE Respondent terminated benefits.

On 7/13/11 Petitioner began treatment with pain specialist Dr. Kerry Panozzo, who diagnosed "myofascial pain of the right trapezius and rhomboid muscles ... due to a myofascial etiology and most likely a tear of the trapezius/rhomboid on the right side." (PX 15). Dr. Panozzo later opined Petitioner's "brachial dysesthesias have resolved, and he's left with this myofascial pain in the same area." (PX 26, p.12). Dr. Panozzo recommended trigger point injections which Petitioner testified was the first treatment he received since his accident that helped his pain. He continued to treat with Dr. Panozzo, receiving injections up to the date of hearing.

When Petitioner saw Dr. Panozzo on 1/24/13 he complained of continued tenderness in his thoracic region. The doctor believed his pain was still emanating from the injury which occurred on 12/7/09. The doctor noted that the four trigger point injections had improved his pain symptomology, which was overall 50% improved from his original injury. It was noted that Petitioner was currently taking less than one hydrocodone every other day. He recommended that Petitioner undergo an additional series of four trigger point steroid injections to see if they can improve his pain symptomology more significantly. Over the next 26 months Petitioner received multiple trigger point injections. By 3/24/14 Petitioner was complaining of low back pain in addition of his thoracic pain. Dr. Panozzo attributed this to "work related event."

On 5/23/14, Petitioner underwent a fourth section 12 evaluation with a pain management specialist, Dr. Howard Konowitz. His diagnosis was resolved brachial dysesthesias secondary to localized trauma. He opined that further work up involving a diagnostic ultrasound and ultrasound guided injection was necessary to determine diagnosis, etiology of the Petitioner's complaints, and necessity of future treatment. In the interim, Dr. Konowitz opined that Petitioner could return to full duty work. (RX 5)

On 3/23/15 Petitioner was again seen by Dr. Panozzo. He continued to report right sided scapular pain. He rated his pain at 3-4/10 up to 7-8/10 at times. The physician again rendered a diagnosis of myalgia. Petitioner underwent an additional right scapular trigger point steroid injection. Dr. Panozzo opined that although Petitioner had reached MMI, he did recommend future trigger point injections to control pain. There was no mention of work restrictions at that time. The record from this visit does not address permanent restrictions, but later notes reference the fact that Dr. Panozzo was awaiting FCE results.

The Arbitrator notes that either the format or the software used by the office of Dr. Panozzo appear to have changed between Petitioner's visits of 12/18/14 and 1/20/15. (PX 15). The earlier notes do not reflect work status in any way. Beginning with the 1/20/15 note the software appears to contain a text box in the history section for "the patient also reports the following factors related to their symptoms:" The note from this visit

indicates "employed full time." The entries for the next few visits are a source of confusion.[1] The Arbitrator, however found Petitioner's testimony regarding his employment status credible.

Petitioner continued to receive trigger point injections approximately every other month.

On 11/2/15 Petitioner underwent the FCE Dr. Panozzo had recommended. The Therapist opined that Petitioner gave a consistent performance throughout testing with some self limiting behavior during material handling due to discomfort. The therapist recommended Petitioner be restricted to no more than 30lbs occasionally.

On 11/16/15 Petitioner was again seen by Dr. Panozzo. Dr. Panozzo opined, "I would put Mr. Englund at MMI. I have reviewed the FCE from OSF with Mr. Englund. The FCE recommends a 30lb weight restriction on him. I would also find it appropriate to have Mr. Englund complete trigger point injections every other month as needed (max of 5 per year)."

After the FCE and receiving his permanent restrictions from Dr. Panozzo Petitioner requested both vocational rehabilitation and maintenance from Respondent on 12/7/15. (PX 20). When nothing was offered Petitioner commenced a job search on his own. (see PX 21, 22). Petitioner testified that he located potential employers by going through the telephone book and making telephone calls. Petitioner's job search records reveal that during the period of 12/29/15 through 3/28/16 he made 61 telephone calls to prospective employers.

Petitioner returned to part time work on 4/21/16 at Crescent Lake Club. Petitioner testified he found the position at Crescent Lake Club because he is on the Board of Directors of the Club. One of their maintence workers quit and they needed to replace him. Petitioner stated he worked 20 hours per week and was paid $10.00 per hour. The job involved mowing with a tractor, light maintenance, and grading roads at a campground. Petitioner testified that it did not exceed his 30-pound weight restriction, as a helper named Jerry did all the heavy work. The job at Crescent Lake Club ended on 10/31/16 due to the seasonal nature of the work. Again turning to Petitioner's job search records, during the period of 11/1/16 through 2/17/17 Petitioner made 45 telephone calls to prospective employers. (PX 22). At the hearing Petitioner testified he does plan to return to this position at the beginning of the season on 5/1/17.

On 5/5/16, Petitioner underwent his fifth and final section 12 evaluation by Dr. Konowitz. He diagnosed T9 right costal transverse ligament pain. He described the injury as myofascial in nature. Dr. Konowitz opined that Petitioner had reached maximum medical improvement. He further opined, that the Petitioner is capable of full duty work. (RX 7)

Respondent obtained surveillance of the Petitioner on two dates. Petitioner can be observed driving various tractors and lawn mowers at the Crescent Lake Club. Petitioner was also observed fishing on a lake. The Arbitrator is not persuaded that Petitioner violated his work restrictions with any of the activities captured on the video. (See RX 9, 10).

Petitioner testified that he would like to participate in vocational rehabilitation. Petitioner testified he cannot return to work as a truck driver due to his 30 pound restriction and inability to pass a DOT physical.

[1] On 3/23/15 the entry is employed full time. On 5/14/15 the entry is unable to work. This note further indicates the doctor is awaiting FCE results. On 7/16/15 the entry reads employed full time. Then on 9/21/15 the entry is unemployed. Etc.

Also, Petitioner testified that he did not believe that he could sit in a truck for hours on end, shift, steer, or disconnect trailers. Petitioner testified he was looking for vocational rehabilitation to get another job that pays as well as the jobs he had before his injury. He said he is unable to return to his usual profession as a truck driver because of his restrictions because of the federal guidelines.

Petitioner continued to receive injections at the approximate frequency recommended by Dr. Panozzo up to the date of hearing. Petitioner testified the injections made it so he could function without taking pain pills every day. Before the injections he had been taking up to seven Vicodin a day. He testified that with the injections he could do things so long as he did not get too carried away. At trial Petitioner testified that his most recent injection of September 2016 had lasted him until the middle of December or January, but his pain was bothering him badly at the time of trial. He indicated he had been taking medication for the pain which was helping a little bit, but was not nearly as effective as the trigger point injections.

CONCLUSIONS

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

It is undisputed that Petitioner sustained injuries on 12/7/09 which resulted in symptoms, including pain in his upper back and scapular region. Respondent initially accepted this claim and began paying benefits. Petitioner was ruled out as a surgical candidate.

In early 2010 Petitioner underwent MRI's of the thoracic spine and right shoulder, which were negative. He saw doctor Michael Dolphin who suggested trigger point injections. (PX 2). Petitioner also saw neurologist Michael Cullen who performed an EMG/NCV, which showed a mild right brachial plexophathy. (PX 3). He was seen at the Illinois Neurological Institute in Peoria, where Dr. Lin had him resume physical therapy. (PX 5).

Petitioner attended multiple section 12 examinations at Respondent's request. He first saw Dr. Salehi on 7/30/10. Dr. Slaehi diagnosed suprascapular nerve injury or an injury to the brachial plexus. Dr. Salehi suggested an injection in the suprascapular notch. He also recommended physical therapy focusing on the shoulder girdle muscles. He was placed on light duty, lifting up to 20 pounds, no push/pulling over 35 pounds. (RX 2).

On 11/3/10 Dr. Salehi opined that Petitioner's symptoms were not consistent with thoracic outlet syndrome and he saw no role for the use of narcotics. Dr. Salehi continued to recommend a suprscapular nerve injection, with possible work conditioning program and FCE to determine restrictions. (RX 3)

On 1/26/11 Petitioner underwent a third section 12 evaluation with Dr. Hagman. Dr. Hagman opined that a clear-cut diagnosis was not possible. He recommended an updated EMG focused on suprascapular nerve innervated musculature of the right shoulder and a functional capacity evaluation. Dr. Hagman believed that Petitioner MMI from nonsurgical care. Dr. Hagman felt Petitioner could return to work on a medium duty basis, yet recommended an FCE to determine restrictions. (RX 4)

On 5/26/11 Petitioner underwent an FCE. It is not clear why there was a four-month delay in obtaining the FCE. The therapist felt that Petitioner's current physical work tolerances were unable to be determined

because of early termination of testing due to pain. (PX 13). Following the receipt of the report regarding the FCE Respondent terminated benefits.

On 7/13/11 Petitioner began treatment with pain specialist Dr. Kerry Panozzo, who recommended trigger point injections as had Dr. Dolphin a year earlier. Petitioner credibly testified the injections were the first treatment he received since his accident that helped his pain. Dr. Panozzo later opined Petitioner's "brachial dysesthesias have resolved, and he's left with this myofascial pain in the same area," localized approximately to T9 and T10 on the right. (PX 26, p.12). He continued to treat with Dr. Panozzo, receiving injections up to the date of hearing.

Petitioner underwent his fourth section 12 examination on 5/23/14. He was evaluated by Dr. Howard Konowitz at that time. Dr. Konowitz diagnosis of resolved brachial dysesthesias secondary to localized trauma is consistent with that of Dr. Panozzo. Dr. Konowitz, however felt that further work up involving a diagnostic ultrasound and ultrasound guided injection was necessary to determine diagnosis, the etiology of Petitioner's complaints, and the necessity of future treatment. In the interim, Dr. Konowitz opined that Petitioner could return to full duty work. (RX 5)

On 3/23/15 Dr. Panozzo opined that although Petitioner had reached MMI, but pointed out that future trigger point injections to control pain. Following his FCE on 11/2/15, Petitioner was again seen by Dr. Panozzo on 11/16/15 and received a 30lb weight restriction. The doctor also reiterated the need for trigger point injections into the future.

On 5/5/16, Petitioner underwent his fifth and final section 12 evaluation by Dr. Konowitz. He diagnosed T9 right costal transverse ligament pain. He described the injury as myofascial in nature. Dr. Konowitz opined that Petitioner had reached maximum medical improvement. He further opined, that the Petitioner is capable of full duty work. (RX 7)

Dr. Panozzo opined the need for injections was causally related to the 12-7-09 incident. (PX 25, p. 27). Dr. Panozzo further opined that Petitioner was at MMI on 3-23-15 and his permanent work restrictions were 30 pound occasional, consistent with the most current FCE. (PX 16).

Dr. Konowitz also opined Petitioner's condition is causally related to the 12-7-09 accident. (RX 6, p. 18). He also agreed that treatment up through his second examination on 5/5/16 had been "reasonable and necessary and related to the injury." (RX 8; p. 21). He did not however feel any further trigger point injections were reasonable. Instead he recommended an ultrasound guided costal transverse joint injection. (*Id.* at 13). Dr. Konowitz opined Petitioner could return to work full duty, without restrictions. (*Id.* at 16, 22). Dr. Konowitz conceeded that Petitioner was not malingering and his pain was real. (*Id.* at 24). He testified that FCE's are one piece of information he uses to determine functional residual ability, but in this case he did not consider any findings from any FCE. (*Id.* at 24-25).

There is some agreement between Respondent's section 12 examiners and Petitioner's treating physicians. To the extent the testimony and opinions of Dr. Panozzo are at odds with those of Respondent's section 12 examiners, which the Arbitrator notes are not necessarily consistent with each other, the Arbitrator finds those of Dr. Panozzo more persuasive.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds that Petitioner has met his burden of establishing that his current condition of ill-being is causally related to the undisputed accident of 12/7/09.

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?

Having previously found the testimony and opinions of Dr. Panozzo more persuasive the Arbitrator finds the medical treatment rendered to Petitioner has been reasonable and neccssary. The Arbitrator further finds Petitioner is entitle d to prospective medical care as recommended by Dr. Panozzo.

Petitioner submitted medical expenses totaling $47,466.02. (PX 17).

Respondent shall pay reasonable and necessary medical services of $47,466.02, as set forth in Petitioner's exhibit 17, 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 prospective medical care as recommended by Dr. Panozzo, as provided in Sections 8(a) and 8.2 of the Act.

Issue (L): What temporary benefits are in dispute?

Issue (O): Is Petitioner entitled to vocational rehabilitation?

Dr. Panozzo found Petitioner to be at MMI, all be it with the need for periodic injections in the future, on 3/23/15. He then placed permanent restrictions of 30 pounds on 11/16/15 following an FCE. Petitioner then requested vocational rehabilitation and maintenance on 12/7/15 and when neither were offered commenced a self-directed job search on 12/29/15. He was able to secure part time seasonal employment on 4/21/16 earning $200 per week. He worked through 10/31/16 when the job ended due to the change of seasons. He did not work again before the date of hearing.

At the time of Arbitration Petitioner testified that he would like to participate in vocational rehabilitation. Petitioner testified he cannot return to work as a truck driver due to his 30 pound restriction and inability to pass a DOT physical. Also, Petitioner credibly testified that he did not believe that he could sit in a truck for hours on end, shift, steer, or disconnect trailers. Petitioner testified he was looking for vocational rehabilitation to get another job that pays as well as the jobs he had before his injury.

Having previously found the opinions of Dr. Panozzo persuasive, the Arbitrator finds that Petitioner reached MMI on 3/23/15, but that permanent restrictions were not set until 11/16/15, following the FCE. The reason for the delay in getting the FCE following 3/23/15 is unclear from the evidence in the record. There is, however nothing to indicate it was due to dilatory behavior on the part of Petitioner. Shortly after receiving the restrictions from Dr. Panozzo Petitioner request vocational assistance and maintenance. While Respondent questions the thoroughness of Petitioner's self directed job search, it is clear from the record Respondent never offered any vocational assistance, and did nothing to assist Petitioner in returning to gainful employment.

Petitioner at least made some effort. Due to Petitioner's limited education and work experience, as well as his unsuccessful self-directed job search, the Arbitrator concludes Petitioner would likely benefit from vocational assistance to allow him to reenter the work force at or near the earning level he enjoyed while working for Respondent.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds Petitioner is entitled to TTD benefits of $453.95 from 12/8/09 through 3/23/15, the date he reached MMI (275 5/7 weeks). Petitioner is entitled to maintenance benefits of $453.95 from 3/24/15 through the date of hearing (98 3/7 weeks). Respondent shall be given a credit for TTD benefits that have been paid. Respondent shall further be given a credit/set off of $200 per week from 4/21/16 through 10/31/16 (25 5/7 weeks), a total of $5,142.86.

The Arbitrator further finds Petitioner is entitled to vocational rehabilitation.

15WC42579
Page 1 of 2

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

Salvatore Mistretta,

Petitioner,

vs. NO: 15 WC 42579

Aramark,

Respondent.

18IWCC0384

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, 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 September 15, 2017, is hereby affirmed and adopted.

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

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

18IWCC0384

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 14 2018
o051718
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

MISTRETTA, SALVATORE
Employee/Petitioner

Case# **15WC042579**

ARAMARK
Employer/Respondent

18IWCC0384

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

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0311 KOSIN LAW OFFICE LTD
DAVID X KOSIN
134 N LASALLE ST SUITE 1340
CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS LTD
TERRENCE M DONOHUE
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF DU PAGE)

☐ 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)

Salvatore Mistretta
Employee/Petitioner

v.

Aramark
Employer/Respondent

Case # **15** WC **042579**

Consolidated cases: **None**

18IWCC0384

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Wheaton**, on **July 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

18IWCC0384

On the date of accident, **August 31, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 $**17,332.64**; the average weekly wage was $**332.32**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $27,454.86, as provided in Sections 8(a) and 8.2 of the Act as documented in PX10.

Respondent shall authorize and pay pursuant to the applicable fee schedule, for continuing treatment with Dr. Salehi, including authorizing the necessary discogram and surgical procedure as Dr. Salehi finds necessary to cure or relieve the petitioner's condition of ill-being.

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

9/12/17
Date

SEP 15 2017

FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on August 31, 2015. Respondent disputes Petitioner's claims and the issues in dispute are: 1) causation, 2) medical expenses and 3) prospective medical care.

On August 31, 2015, Petitioner worked for Respondent as a driver's aid. Respondent provides breakfasts and lunches for students of West Chicago School District 33. Meals were prepared out of the Leman Middle School (Leman) facilities and then driven to the individual schools in the district to be set-up and served to the students.

Petitioner's duties were to arrive at Leman at 6:00 a.m. and load cases of food onto the delivery trucks. He was required to lift and carry 30 to 40 cases of food weighing between 40 to 60 pounds each to load the trucks. Thereafter, he would work in the kitchen preparing food for the students. Hot food would then be stacked into seven foot tall by four-foot wide carts, weighing approximately 800 pounds, to be rolled onto the lift-gate of the trucks for delivery to the individual schools. Petitioner testified that it took two people to bend and lift the front of the carts to get them onto the lift-gate. Petitioner would then travel with the driver and unload the food at the individual schools. He would then stay at Pioneer Elementary School and set-up lunch in the gymnasium for the students. Petitioner would then breakdown the lunch products, load them onto the truck and then travel with the truck to the other schools, retrieving their products and carts to bring them back to Leman. Once at Leman petitioner would unload the trucks and return cases of bottled water to storage. Petitioner testified that he would lift and carry 25 to 30 cases of water weighing 20 to 25 pounds each on a daily basis.

Petitioner testified that, prior to the stipulated accident of August 31, 2015 he had no difficulty performing any of his job duties, including the heavy repetitive lifting his position required. Petitioner further testified that at no time prior to his work injury did he experience low back and leg pain, nor did he need assistance performing the loading and unloading or other heavy lifting associated with his job duties. Petitioner admitted to having a previous diagnosis of right hip bursitis, but this pre-existing condition of his right hip did not cause him any limitation prior to his work injury.

On August 31, 2015 the petitioner was at Pioneer Elementary School to serve lunch to the students. In order to breakdown the service in the gymnasium, the petitioner had to roll up a rubber mat which was placed over electronic cords to prevent the students from tripping. The petitioner had finished rolling the mat and was cradling it with both arms under his chin when he bent down to place the mat into a cabinet. While doing so, his feet slipped out in front of him on water left on the floor by a janitor mopping the area. This caused the petitioner to fall backwards onto his buttocks in a sitting position. Petitioner testified that he fell hard and was in shock. Within ten minutes he began to experience sharp pain in his tailbone and buttocks.

Petitioner testified that he finished his work day including lifting and restocking the cases of water. At approximately 1:30 a.m. that afternoon the petitioner spoke to his supervisor, Donna Whims, in her office at Leman. He advised Ms. Whims that he had fallen on mop water and that his back was painful. Ms. Whims asked if the petitioner wanted to fill out an accident report, but the petitioner stated that he wanted to see if the pain would subside on its own. He declined medical referral at that time.

Ms. Whims was called to testify by Petitioner's counsel. She is the respondent's Director of Food Service for West Chicago School District 33. Ms. Whims confirmed that Petitioner reported his accident to her on the date in question and informed Ms. Whims that he did not want to make a report because he did not want to get the

school district employee who mopped the floor in trouble. Although Ms. Whims stated that filing a report would not get the petitioner in trouble with the respondent, she did acknowledge that circumstances were "politically charged" which could affect the respondent's contractual relationship with the School District. She agreed to not file an accident report on August 31, 2015 upon petitioner's request.) Ms. Whims testified that petitioner appeared to move slower and more cautiously following the August 31, 2015 accident, and that he was never the same after August 31, 2015 through September 18, 2015 when she sent the petitioner to Concentra for his continuing back complaints.

That evening the petitioner's pain did not subside. The next day the petitioner arrived for work late at 6:20 a.m. His back was still painful and it was difficult to move. When entering Leman the petitioner saw his co-employee, Manuel Vega, loading the trucks in place of the petitioner. Mr. Vega joked that the petitioner walked like an old man. Mr. Vega voluntarily assumed the loading and unloading duties while allowing the petitioner to strictly perform food preparation. Petitioner testified that his pain slowly became worse though he elected to refrain from seeking medical attentions, hoping that the pain would subside.

Mr. Vega was called to testify by Petitioner's counsel. On August 31, 2015 Mr. Vega was in charge of kitchen production for Aramark at Leman. He was familiar with petitioner as an Assistant Truck Driver who began his day at 6:00 a.m. Mr. Vega would see petitioner on a regular basis at work. Prior to August 31, 2015 Mr. Vega testified he noted the petitioner to be fast moving and that the petitioner had no issues performing his job duties, including loading and unloading. Following the August 31, 2015 accident, Mr. Vega saw the Petitioner limping. Mr. Vega assigned the petitioner to food preparation. Mr. Vega took over all of petitioner's loading and unloading duties voluntarily. Mr. Vega testified that the petitioner was in pain from the very next day after the August 31, 2015 accident until the date that Mr. Vega left the Leman position in June 2016. Mr. Vega would ask the petitioner every day how he was feeling and petitioner would always answer that he was still in pain. Petitioner continued to move slowly and cautiously every day. Mr. Vega voluntarily undertook the loading duties even though the petitioner did not have formal work restrictions for the first few weeks after his initial injury. Thereafter, when the petitioner obtained formal restrictions, petitioner was assigned to food preparation permanently in accommodation of his restrictions. Mr. Vega testified that petitioner's work restrictions did not limit his work hours.

Petitioner testified that from September 1, 2015 through September 10, 2015, his back condition was gradually worsening. On September 10, 2015 he had a reaction to a drug taken due to a laceration, which caused him to break out in a rash and gave him difficulty with breathing. He went to a satellite emergent care clinic on September 10, 2015 with complaints of shortness of breath and a rash. At the emergent care clinic, Petitioner did not mention his back condition as he was focused on his problems with breathing.

Petitioner testified that his back was getting tighter and he was unable to bend down from September 1, 2015 through September 18, 2015. On September 18, 2015, Petition reported his increasing back pain to Ms. Whims, who authorized Petitioner to go to Concentra in Bloomingdale. Petitioner went to Concentra later that day, where he was given X-Rays and referred to Dr. Sean Salehi. Petitioner continued to see Dr. Salehi, who recommended the Petitioner undergo physical therapy 2-3 times per week for 4 to 6 weeks to concentrate on core strengthening exercises, and also to see Dr. Heller for one or two bilateral L3-4 and L4-5 facet injections. He was given a prescription for Mobic and Ultram. He was continued on light duty restrictions of no lifting more than 20 pounds, no pushing or pulling more than 35 pounds, and no bending or twisting more than 3 times per hour and the ability to alternate sitting and standing every 30-45 minutes. Petitioner underwent physical therapy at ATI.

On May 3, 2016 the Petitioner was seen by Dr. Zindrick. (PX 6) The Petitioner presented as a 59-year-old male with low back and bilateral hip pain, right equal to left. His pain is 70% low back and 30% bilateral hips. It ranges from 5-10/10. He recounted injuring himself at work slipping on a floor on August 31, 2015. On examination of his lumbar spine flexion was to 90°, extension 30°, side bending to 30°. He had tenderness over the paraspinals. He reported pain during extremes of all motions. Straight leg raising was negative on the left and right with negative Babinski test. He had a full range of motion of both hips without pain. Impression was lumbar degenerative disc disease L-2-3 to L4-5, spondylosis L3-4 and L4-5, and central stenosis L3-4 and L4-5 made symptomatic by fall at work aggravating a pre-existing condition. The recommendation was bilateral epidural spinal injections at L3-4 and L4-5 levels, and to continue current work restrictions.

On June 28, 2016 the Petitioner saw Dr. Heller on referral from Dr. Salehi. The referral was for bilateral L3-4 and bilateral L4-5 facet joint injections. The injections were administered. (PX 2B) Following the injections, the Petitioner continued to follow up with Dr. Salehi, who prescribed therapy, including work conditioning. Because of Petitioner's continued complaints of pain during his therapy, Dr. Salehi recommended Petitioner undergo a fusion. Petitioner testified that he wishes to proceed with the treatment recommended by Dr. Salehi should this Commission order same.

Dr. Salehi testified via evidence deposition on April 25, 2017. He is a board-certified neurosurgeon who first examined the petitioner on November 13, 2015. The petitioner gave a history of slipping on a wet floor and falling onto his right hip and buttocks while at work on August 31, 2015. The petitioner complained of pain radiating across his low back, into his right hip and radiating into his right lateral thigh. (PX8 p.9) Dr. Salehi advised obtaining MRIs to petitioner's right hip and lumbar spine. The MRI to petitioner's right hip was negative. (PX8 p.82) Dr. Salehi identified three issues on the petitioner's lumbar MRI. First, the MRI identified narrowing of the spinal canal and foramen where the nerves come out (stenosis) most significantly at L4-5, but also to a moderate degree at L3-4. Second, the MRI noted degenerative disc disease over multiple lumbar levels (L2-3 through L4-5) showing annular tears and disc dehydration. Third, the MRI noted facet arthropathy. Dr. Salehi described each condition as a competent source of petitioner's complaints of pain. (PX8 p15) Dr. Salehi testified that, anatomically speaking, a lot of these conditions pre-existed the petitioner's work injury of August 31, 2015. Dr. Salehi opined that the petitioner's fall onto his buttocks on August 31, 2015 was a competent cause to aggravate or worsen these objective findings to cause petitioner's condition to be symptomatic. (PX8 p17) He based his opinion upon the fact that the petitioner had no complaints of low back or radicular pain down his legs prior to August 31, 2015. The petitioner began having low back pain immediately after his fall at work. The findings present on the lumbar MRI are consistent with the petitioner's complaints of ill-being.

Dr. Salehi testified that petitioner's history, that he had pain immediately after his August 31, 2015 fall is consistent with his opinion of causal connection. He opined that such symptoms could begin immediately or up to five days after such a traumatic event, depending upon the individual's inflammatory response. (PX8 p41) Petitioner's disc bulges may have acutely become larger due to the fall, but without a previous MRI, there is no way to tell. (PX8 15) Further, Dr. Salehi noted the petitioner's significant, yet temporary, relief from the facet injections as confirmation that the petitioner's symptoms are coming from his lumbar spine pathology. (PX8 p33) Dr. Salehi has prescribed a lumbar discogram followed by decompression and fusion of those lumbar disc levels found to be the cause of petitioner's pain in his low back and radiating into his legs. (PX8 p38) At the present time the petitioner can and has been allowed to work full hours, but with limitations of 20 pounds lifting and 35 pounds pushing and pulling. Per Dr. Salehi, the petitioner is not at maximum medical improvement and requires surgical decompression and stabilization after the discogram.

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Dr. Julie Wehner testified via evidence deposition on May 5, 2017. She is a board certified orthopedic surgeon who examined Petitioner at Respondent's request on January 27, 2016. Based upon her review of the records as well as her examination of the petitioner, Dr. Wehner opined that the petitioner's work injury on August 31, 2015 caused the petitioner to sustain a simple sprain to his buttocks. (RX2A p23) Dr. Wehner based her opinions on the petitioner's lumbar MRI, which showed significant pre-existing disc degeneration at L2 through L5. It is her opinion that this condition takes years to develop and that these specific findings pre-date the petitioner's August 31, 2015 accident. She saw nothing acute on the MRI that can be related to the fall. Dr. Wehner further opined that the stipulated accident of August 31, 2015 did not aggravate petitioner's pre-existing lumbar stenosis because petitioner did not present for medical treatment until September 18, 2015. Further, the petitioner was examined in an emergent care facility on September 10, 2015 with no mention of a recent fall or documented complaints of back or leg pain. She noted negative neurologic and musculoskeletal findings in that record. Dr. Wehner pointed to the treating records of Concentra's occupational clinic for the dates of October 1, 2015 and October 8, 2015 stating that those records show no complaints of low back pain. Further, Dr. Wehner testified that the findings on the lumbar MRI would cause neurogenic claudication, meaning pain while walking, which was not a complaint noted by the petitioner. (RX2A p25) Based upon the above Dr. Wehner opined that the petitioner did not suffer from symptomatic stenosis, that he merely suffered a resolved sprain and that petitioner was at MMI and capable of returning to full duty.

Dr. Carl Graf testified via evidence deposition on June 1, 2017. He is a board certified orthopedic surgeon who examined the petitioner at respondent's request on November 3, 2016. The petitioner provided Dr. Graf a consistent history with respect to the circumstances of his work injury as well as his course of treatment and complaints thereafter. (RX3A p8) Dr. Graf acknowledged that there was no evidence that the petitioner had complaints of low back or pain radiating into his legs prior to the August 31, 2015 work injury. (RX3A p11) From the moment petitioner walked into his office, Dr. Graf noted the petitioner to have an antalgic gait (claudication), shifting to the left, which he found to be a clear indication of symptomatic spinal stenosis. (RX3A p13) Dr. Graf found his exam to be consistent with that diagnosis except for a single inconsistent finding of pain with axial rotation. Dr. Graf noted this finding to be insignificant and specifically noted that the petitioner was not malingering or disingenuous in any manner. (RX3A p49) Dr. Graf declared the petitioner to be quite reasonable in his presentation. (RX3A 56) Based upon his examination of the petitioner as well as his review of all the records available, Dr. Graf opined that the petitioner suffers from lumbar stenosis at three levels, L2-3, L3-4 and L4-5. He believed that the levels of L3-4 and L4-5 to be moderate to severe. (RX3A p24-25) Dr. Graf opined that the petitioner's lumbar stenosis is degenerative and pre-existed his injury of August 31, 2015. (RX3A p25) He did not believe petitioner's complaints are discogenic. He opined that the findings on the lumbar MRI are not acute. Dr. Graf concluded based upon the emergent care records of September 10, 2015 and the fact that the petitioner did not seek medical attention for his low back and leg complaints until September 18, 2015, that his current condition of ill-being is not related to the accident of August 31, 2015. (RX3A p26)

Despite his opinion regarding causal connection, Dr. Graf opined that the petitioner is not at MMI and needs work restrictions to be accommodated (RX3A p60-61) Further, while he disagreed with Dr. Salehi that the petitioner requires a fusion, Dr. Graf agreed that the petitioner does require decompression surgery alone. (RX3A p28) He did not advise on a fusion. Likewise, he did not find the use of a pre-surgical discogram to be reasonable because, in Dr. Graf's experience it is not necessary if surgery was limited to decompression and did not include fusion. (RX3A p31) Dr. Graf did find the petitioner's complaints of leg give-away to be credible and consistent with his diagnosis of lumbar stenosis. (RX3A p32)

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Dr. Graf testified that he was not presented with any evidence from other sources consistent with the petitioner experiencing back pain, radicular leg pain, difficulty walking or difficulty standing beginning immediately after the accident of August 31, 2015. Dr. Graf testified that, if he were presented with such facts, he would reserve his right to change his opinions. (RX3A p58) Dr. Graf admitted that the slip and fall accident described by the petitioner could be a competent cause of aggravating petitioner's pre-existing spinal stenosis, leading to his current condition of ill-being. (RX3A p57) Dr. Graf believed discograms are reasonable if the patient's pain is coming from a disc. (RX3A p57)

At the time of his evidence deposition, Dr. Salehi responded to those opinions disclosed by Drs. Wehner and Graf in their reports. (PX8 p39) Dr. Salehi agreed with Dr. Graf that the petitioner's diagnosis is multilevel lumbar spondylosis and lumbar stenosis. (PX8 p39) Dr. Salehi disagreed with Dr. Graf's opinion that there is no discogenic component to petitioner's condition. Dr. Salehi noted that the annular tears themselves are discogenic and produce bulging, which is a cause of petitioner's current complaints of ill-being. Dr. Salehi noted the petitioner's history wherein he immediately experienced pain in his low back after the August 31, 2015 accident. (PX9 p40) Dr. Salehi noted that it is not unreasonable for someone with a back complaint after an accident to wait with the hope that the pain is passing in nature. (PX9 p41) Dr. Salehi noted that the emergent care note from September 10, 2015 is not inconsistent with petitioner's testimony. Dr. Salehi pointed to the fact that the petitioner was seen only for his rash and difficulty breathing. Dr. Salehi noted that the emergency personnel would have primarily been concerned with the inability to breath and the stated reason the petitioner appeared for treatment. Dr. Salehi noted that the neurological exam is specified to be limited to petitioner's complaints of dizziness and that the neurological exam seemed to be limited to petitioner's head and mental status.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the testimony of the various witnesses and the medical evidence. Essentially, this dispute boils down the to the question of whether the Petitioner's undisputed accident on August 31, 2015 aggravated his pre-existing back condition. Respondent contests causal relationship by pointing to the emergent care office record of September 10, 2015 wherein there is no mention of a work injury or low back and radicular pain at all. Respondent also points to the fact that the first medical treatment obtained by the petitioner for his low back pain was not until September 18, 2015. Petitioner's explanation for waiting 18 days to receive medical treatment for his back is that he was hoping the pain would go away. Petitioner credibly testified that as time went by from the time of his reporting the accident to his supervisor on the undisputed accident date, to his follow-up meeting with his supervisor on September 18, 2015, his back pain continued to worsen to the point his supervisor authorized him to go to Concentra, the Respondent's company clinic, which then referred Petitioner to Dr. Salehi. And while there is no dispute that the Petitioner's back condition was pre-existing, there was no evidence indicating the Petitioner had back symptoms or medical treatment for his back prior to the August 31, 2015 accident. The Arbitrator notes that both Drs. Salehi and Graf opined that the mechanism of injury was competent to cause an aggravation of petitioner's per-existing condition. (PX8 p41) Dr. Salehi and Dr. Graf agree that the lumbar MRI findings were objectively competent for causing petitioner's current condition of ill-being. Dr. Salehi notes that the examining physicians do not account for the fact that there is no medical evidence that the petitioner suffered from low back or radicular pain prior to August 31, 2015. Accordingly, the Arbitrator finds persuasive Dr. Salehi's opinions and concludes that the Petitioner's condition, for which he now recommends surgery, is causally related to the August 31, 2015 accident.

2. With regard to the issue of medical expenses and consistent with the Arbitrator's conclusions on the issue of causation, the Arbitrator finds that the Petitioner's medical treatment related to his back as indicated in the medical evidence, has been reasonable and necessary. Accordingly, the Arbitrator awards the Petitioner any related medical expenses, including the unpaid medical bills in the amount of $27,454.86 as per PX10. The Arbitrator notes the parties' stipulation that, if so awarded, the respondent may make payment directly to the providers pursuant to the applicable fee schedule.

3. Based on the Arbitrator's conclusions with regard to the issues of causation and medical expenses, the Arbitrator further finds that the Petitioner's request for prospective medical care is reasonable, related and necessary in the treatment of his work-related back condition. In support of this finding, the Arbitrator finds persuasive the opinions of Petitioner's treating physician, Dr. Salehi, who was referred by the respondent's company clinic. Accordingly, the Arbitrator awards the Petitioner the prospective medical care as recommended by Dr. Salehi, including the suggested discogram and surgical procedure as Dr. Salehi finds necessary to cure or relieve the petitioner's condition of ill-being.

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

Bobbi Jo Henry,
Petitioner,

vs.

NO: 11 WC 33130
11 WC 24580

Den Graphix,
Respondent.

18IWCC0385

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 December 19, 2017, is hereby affirmed and adopted.

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

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

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

DATED: JUN 14 2018
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DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HENRY, BOBBI JO
Employee/Petitioner

Case# **11WC033130**
11WC024580

DEN GRAPHIX
Employer/Respondent

18IWCC0385

On 12/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2284 LAW OFFICES OF LAWRENCE COZZI
27201 BELLA VISTA PKWY
WARRENVILLE, IL 60555-1619

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

Bobbi Jo Henry
Employee/Petitioner

v.

Den Graphix
Employer/Respondent

Case # 11 WC 33130

Consolidated cases: 11 WC 24580

18IWCC0385

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Bloomington**, on **5/25/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0385

FINDINGS

On **3/17/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident *was 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 **$14,475.24**; the average weekly wage was **$278.37**.

On the date of accident, Petitioner was **41** years of age, *married* with **1** dependent child.

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

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

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

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

ORDER

Because Petitioner failed to prove that she sustained an accident which arose out of and in the course of her employment with Respondent, and failed to prove that notice of the alleged accident was provided to Respondent within 45 days as required by the Act, benefits are denied.

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

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

Michael K. Nowak, Arbitrator

12/14/17
Date

DEC 19 2017

18IWCC0385

BACKGROUND

Petitioner has a 20 plus year history of low back pain with radicular symptoms. Petitioner testified she first received treatment for her lower back in 2006. As of that time, she had been experiencing low back pain for almost 20 years. Her treatment included medications, physical therapy, epidural steroid injections, and a discogram. Petitioner also attempted a trial spinal cord stimulator on three separate occasions. She acknowledged the attempt at using a spinal cord stimulator was a last ditch effort to help her back pain and get her off of opiates. Petitioner indicated that on each of the three attempts, Dr. Vallejo from Millennium Pain Center punctured her spinal cord. Petitioner refused to undergo any further attempts. She also testified she knew she was going to continue having back trouble.

Petitioner has two pending cases against Respondent which were consolidated for hearing. Case number 11 WC 024580 corresponds with the alleged accident date of April 20, 2011 and case number 11 WC 033130 corresponds with an alleged accident date of March 17, 2011. Both claims allege injury to "legs, back and other parts of the body." Two different attorneys appeared on behalf of Respondent, one for each claim.

FINDINGS OF FACT

Petitioner testified that as of March 17, 2011 she had been employed by Respondent for 4-5 years. She worked as an embroidery tech, and her job duties included running an embroidery machine, working with clothing, hooping materials, and unloading boxes delivered by UPS. Petitioner testified her physical activities included bending, stooping, twisting, moving boxes, and moving clothing around.

Petitioner also testified her job station is in the shape of an "L," so she did a lot of moving back and forth while twisting her body. Petitioner further testified her left knee twisted back and forth when removing things from the embroidery machine and then placing them over on her work station. Petitioner indicated she performs the twisting maneuver 100 times per day as part of what she described as the repetitive motion of her job. When describing the physical components of her job duties, Petitioner testified she worked with her body in a bent over position 75% of the day. When describing the job analysis set forth in Petitioner's Exhibit 9, Petitioner indicated her body is in a bent position 1/3 to 2/3 of the day, and she has bend, stoop, and squat 1/3 to 2/3 of the day.

Petitioner testified that on March 17, 2011 she was holding a box, and when she twisted to the left to move it she heard a pop in her left knee. (TR p. 15) She stated that she noticed immediate pain in the knee and shortly thereafter noticed back pain which she described as "different" than that which she had experienced over the 20 years prior. (Id. at 17) She indicated she could no longer pick up boxes. During the cross-exam by Respondent's counsel for the March 17, 2011 alleged accident, Petitioner testified that the March 17, 2011 alleged accident occurred when she squatted down to pick up a box, and when she stood back up, she heard and felt a snap in her left knee. Id. at p. 31-32) Petitioner testified she did not know if she hurt her back that day, but because of her knee being weak, her back started bothering her.

The Petitioner testified that other people were in the shop working at the time of the alleged accident, but she did not mention the incident that day to anyone, either to co-workers or to supervisors. She testified that she did, however report the injury at a later date. However, she is not sure when she told a supervisor about her

knee. She did not even know the month when she first told a supervisor about her knee. She remembers being in Bill Frautschi's office, speaking with Bill Frautschi and Phil Wieland. No forms were completed. She testified she proposed to Frautschi and Wieland that they put her on "temporary layoff." Specifically, Petitioner testified:

> I had stated to them, instead of filing a Work Comp case against them, that I would use my insurance and I would take care of it myself if they would give me temporary layoff so that I still had income for my family until I could come back to work. . . . That, once I was done with my surgery and physical therapy, I would come back to work; and they didn't want any part of that. I don't know how you'd call it, offer to keep my job, but still have an income. I was the only income for my family; and that's whenever I told them that I would have to file a Work Comp case against them then. (TR p. 35-36)

Petitioner testified that she was not sure whether she described how the left knee injury occurred during the meeting. She testified clearly that she was not sure when she told the Respondent about the left knee incident.

Also during the cross-exam Petitioner testified she described the March 17, 2011 incident to Dr. Kube, the doctor at McLean County Orthopedics and to physicians assistants.

Petitioner testified daily activities make her back worse. Petitioner also testified that in early 2011 before the incident involving her knee occurred, she was taking Percocet for her back pain. She had been on Percocet for several years prior to March 2011.

Petitioner suffered a stroke in July 2010. As of March 17, 2011, she was up to working five hours per day if not more. Petitioner indicated the employer was good about allowing Petitioner to ease back into her job duties.

With respect to the April 20, 2011 alleged accident, Petitioner testified that nothing happened on that day. She also testified she did not remember her condition getting worse for any reason on that day. (TR p. 62)

When Petitioner reported to her primary care physician, Dr. Brenda Kube on March 17, 2011 she provided a history of having pain in her left knee which felt like it was bone rubbing against bone. Petitioner also indicated she ran out of Percocet a few months earlier. Petitioner complained of ongoing very severe pain in her lower back which radiated down the back of the leg and into the foot. Petitioner reported that she occasionally ends up tripping and dragging her foot. Petitioner told Dr. Kube that she was down to working only five hours per day and she was on her feet all day at her current job. Dr. Kube's note expressly states there has been no recurrent injury. Dr. Kube referred Petitioner for an MRI of the left knee as she suspected a torn meniscus. She also referred Petitioner to Dr. Seibly for a consult regarding the lower back. Dr. Kube commented Petitioner was seeing Dr. Seibly for a previous brain aneurysm as well.

An MRI of the left knee was performed March 23, 2011. The report indicates Petitioner had mildly increased joint effusion in the left knee as well as evidence suggesting a complex tear of the medial meniscus. (Px 4)

Dr. Kube referred Petitioner for an orthopedic consult at McLean County Orthopedics. Petitioner was next evaluated by a physician's assistant, Alicia High April 7, 2011. (Px 19) Petitioner reported her primary complaint was numbness in the left leg. She acknowledged a long-term history of chronic low back pain as well as her current symptoms being present for several months. Petitioner reported no history of an injury to her back, hip, or knee. Based upon her exam, Ms. High thought the symptoms were most consistent with lumbar radiculopathy, and she suggested deferring any potential surgical intervention on the left knee until after Petitioner was evaluated by Dr. Seibly.

An MRI of the lower back was performed April 13, 2011. (Px 5) The report indicates Petitioner had degenerative disc disease at L4-5 and L5-S1 with a left-sided disc herniation at L5-S1.

On April 22, 2011, Petitioner reported to the Advocate BroMenn Medical Center emergency room. (Rx 3) Petitioner provided a history of a brain aneurysm, hypertension, a CVA, and degenerative disc disease in her back. Petitioner complained of left leg pain and numbness. Her primary complaint was a slight bluish discoloration to her toes on the left foot. Petitioner denied any trauma or other complaints, but she provided a history of a nerve stimulator being placed two previous times without any relief from her back discomfort. Petitioner reported she was currently taking Oxycodone. Petitioner was advised to stop smoking. A Doppler study of the left leg only showed some mild atherosclerosis.

At trial, Petitioner testified the reason she went to the emergency room April 22, 2011 was because of the discolored toes on her left foot. She also testified the doctors were never able to come up with a reason for the discolored toes.

Following the emergency room visit, Petitioner returned to see Dr. Kube April 25, 2011. (Px 15) Dr. Kube noted there was no new injury. Dr. Kube suspected Raynaud's phenomenon of the foot secondary to a neurological disorder in the back.

Dr. Seibly evaluated Petitioner April 28, 2011. (Px 18) Petitioner's main complaint involved in her chronic low back pain with left leg pain radiating in the left SI distribution. Petitioner reported her back pain had been going on for years and she had seen pain management doctors on several occasions and had a previous spinal cord stimulator attempt by Dr. Vallejo. Petitioner indicated her pain was significantly worsened over the previous three weeks. She also told Dr. Seibly her symptoms were aggravated by movement, and she was unable to tolerate her job as an industrial line worker for an embroidery company.

Dr. Seibly noted the MRI of the lumbar spine showed diffuse degenerative disc disease, but it was very mild and there was no significant impingement on the left S1 nerve root. Dr. Seibly did not believe surgical intervention was required. He did refer Petitioner to Dr. Benyamin for a possible selective nerve root block for pain control. He also referred Petitioner to Dr. Jhee for a physiatry consultation.

Petitioner completed a workers' compensation questionnaire May 1, 2011 for West Bend Insurance Company for an alleged date of loss April 20, 2011. The form was completed by Petitioner and indicates she had been off work since April 20, 2011, but there is no indication as to an accident occurring April 20, 2011.

Petitioner was evaluated by Dr. Craig Carmichael May 9, 2011. Dr. Carmichael's note does not contain any history of an accident in the workplace. (Px 16)

A First Report of Injury was prepared May 10, 2011. (Px 7) The report lists an alleged accident date of April 20, 2011. It describes the accident as "normal activities." There is no indication that a specific work accident or an aggravation of a pre-existing condition occurred.

Petitioner completed a new patient history form for McLean County Orthopedics on July 18, 2011. Petitioner wrote that her knee pain was first noticed April 20, 2011. (Px 10)

Dr. Mark Hanson, an orthopedic surgeon, evaluated Petitioner July 20, 2011. The history indicates Petitioner twisted her left knee at work and developed medial pain with giving way and swelling. Following an exam and a review of the MRI study of the left knee, Dr. Hanson recommended an arthroscopic procedure consisting of a partial medial meniscectomy. (Px 17)

Dr. Carmichael administered an epidural steroid injection at the L5 level of the lumbar spine July 22, 2011. (Px 12)

Dr. Hanson performed surgery on Petitioner's left knee August 11, 2011. The procedure consisted of a partial medial meniscectomy, a chondroplasty of the lateral tibial plateau, and chondroplasty of the patella. (Px 14)

Petitioner underwent a course of physical therapy following the surgery. On October 18, 2011, Dr. Hanson discharged Petitioner from care with respect to the left knee and indicated Petitioner was capable of working in a full-duty capacity with respect to her left knee. (Px 17)

At the request of counsel for the employer with respect to the April 20, 2011 alleged accident, Dr. James Kohlmann performed a record review and prepared a report dated October 29, 2012. Dr. Kohlmann rendered an opinion that there was no causal relationship between Petitioner's left knee condition or her lower back condition and her job duties.

At the request of Respondent's insurance carrier for the March 17, 2011 claim, Petitioner was evaluated by Dr. Lawrence Li on October 30, 2012. Dr. Li rendered an opinion there was no history of a work accident immediately following the alleged accident March 17, 2011, so he did not believe there was a work injury.

Both Dr. Kohlmann and Dr. Li testified by way of evidence deposition, as did Dr. Hanson and Dr. Carmichael.

Dr. Hanson's deposition was taken on January 7, 2015. Dr. Hanson is an orthopedic surgeon who treated Petitioner for her left knee condition. Dr. Hanson testified about the treatment he provided to Petitioner including an arthroscopic surgery on the left knee. He also testified that he subsequently treated Petitioner for her right knee which Petitioner described as having similar symptoms to those which she previously had in the left knee. (Px 1, p.11) Based upon a hypothetical question which included Petitioner turning and twisting with a box weighing 25 pounds on April 20, 2011 and suffering from increased knee pain, Dr. Hanson testified the described maneuver could have caused or aggravated the medial meniscus tear in Petitioner's left knee. (Px 1,

pp.12-13) On cross-examination, Dr. Hanson testified his causal connection opinion was based upon an assumption that Petitioner was asymptomatic, had an incident April 20, 2011, and then became symptomatic in her left knee. (Px 1, p.22) After reviewing the date of the MRI of the left knee as well as the treatment note from Dr. Kube dated March 17, 2011, Dr. Hanson testified that within a reasonable degree of medical certainty, Petitioner was suffering from a left medial meniscus tear as of March 17, 2011. Dr. Hanson also testified Petitioner was suffering from a complex tear which was more consistent with a degenerative tear as opposed to a traumatically induced acute tear. (Px 1, p.26) Furthermore, based upon Petitioner reporting left knee pain to her family physician March 17, 2011, an MRI showing the same findings as were identified during Dr. Hanson's surgery and medical records failing to document any history of an accident April 20, 2011, Dr. Hanson testified that within a reasonable degree of medical certainty, the alleged accident date of April 20, 2011 was not accurate. (Px 1, pp.31-32)

Dr. Craig Carmichael testified by way of evidence deposition on October 6, 2016. Dr. Carmichael is a physical medicine and rehabilitation physician. He testified about the treatment he provided for Petitioner including an epidural steroid injection for her lumbar spine and an EMG study which revealed findings consistent with an L5 radiculopathy. Dr. Carmichael testified the job duties as reflected on Petitioner's Exhibit 9 could have aggravated Petitioner's lumbar spine condition. (Px 22, p.16) On cross-exam, Dr. Carmichael clarified his causal connection opinion by indicating it was based upon Petitioner suffering from a repetitive trauma injury as opposed to a particular event. (Px 22, p.22) Dr. Carmichael further testified he was not aware of any specific incidents or accidents Petitioner had in the workplace. (Px 22, pp.36-37) Dr. Carmichael also testified he was not aware of any changes in Petitioner's condition, symptoms, anatomy, or pathology between the time of the lumbar MRI study April 13, 2011 and the time of his first evaluation of Petitioner May 9, 2011. (Px 22, p.39) Additionally, Dr. Carmichael testified the injection he administered July 22, 2011 was to treat the pathology identified on the April 13, 2011 MRI study. (Px 22, p.39) Dr. Carmichael also testified that the emergency room visit relating to the discoloration of Petitioner's toes was not related to her back. (Px 22, pp.40-41)

Dr. James Kohlmann provided his deposition testimony on January 2, 2014. Dr. Kohlmann performed a record review at the request of Respondent. Dr. Kohlmann testified Petitioner's low back condition was not causally related to her job duties. Additionally, Dr. Kohlmann testified the medical records did not document an injury or accident which would have caused the problem with her knee. (Rx 2, p.13)

Dr. Lawrence Li's evidence deposition was taken on July 1, 2013. Dr. Li is an orthopedic surgeon who performs surgery on the extremities and treats spinal issues non-surgically. Dr. Li performed an IME of Petitioner on October 30, 2012. Dr. Li testified that based on the history provided to him by Petitioner, he believed Petitioner suffered from a temporary increase in symptoms in her lower back which resolved. (Rx 1, p.17) On cross-exam, Dr. Li confirmed that the surgery performed on Petitioner's knee August 11, 2011 was done to address the findings identified on the MRI study performed March 23, 2011. (Rx 1, pp.37-38) Dr. Li also confirmed that it was his opinion that there was no causal relationship between Petitioner's job duties and the condition of her lower back or the condition of her knee. (Rx 1, pp.46-47) Furthermore, Dr. Li testified that if Petitioner suffered from any type of aggravation of a pre-existing condition to either her back or her knee, those aggravations would have occurred before the MRI studies were done. (Rx 1, p.47)

At trial, Petitioner testified she was currently performing the same job duties as she was for Respondent. She further indicated she was doing great.

Petitioner also testified about other jobs she performed between the time she was discharged from care by Dr. Hanson and the time of trial. Petitioner indicated she performed retail merchandising work which involved tearing down metal shelving units and rebuilding them and moving displays of merchandise. Petitioner explained the merchandise consisted of grocery products and housewares. She also put together grills and outdoor furniture as part of her job duties. Petitioner acknowledged her job duties involved a fair amount of bending over and stooping, but those activities did not bother her back. Those activities also did not bother her knee despite having to bend down and squat.

Petitioner testified to working as an assistant manager at a Subway restaurant. She acknowledged having to be on her feet for the entire time she was working. She further testified her job duties included preparing foods, making sandwiches, running a cash register, and running the drive-thru. Additionally, Petitioner had to unload a truck consisting of bulk items of food. Petitioner indicated the boxes were up to 15 pounds, and she also had to unload bags of onions which weighed about 75 pounds. Petitioner indicated she had trouble lifting the 75 pound bags of onions, but that particular job duty did not make her back any worse.

The one other job Petitioner testified about was that she tended bar on a part-time basis for about five months.

At the time of trial, Petitioner testified she does not have any problems with her knee now that she had it worked on. She further testified she does not have any problems standing for long periods of time. Petitioner then testified she has some problems with her left knee, but she was sure a lot of that was just old age.

With respect to her lower back, Petitioner testified she does not have as many problems as she did. On cross-exam, Petitioner further explained she has not had any problems with her back since undergoing physical therapy following the knee surgery.

CONCLUSIONS

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

Issue (E): Was timely notice of the accident given to Respondent?

With regard to 11 WC 24580, alleged accident date of April 20, 2011

The Arbitrator notes that Respondent did not dispute notice with regard to this claim.

Petitioner testified that nothing happened on April 20, 2011. She also testified the condition of her low back and left knee were not worsened on that day.

The medical evidence establishes Petitioner has a long history of low back issues. Additionally, Petitioner testified that on March 17, 2011, she twisted her knee at work and subsequently developed increased low back pain because of the weakened knee.

The initial medical records from Dr. Kube, Alicia High, Dr. Seibly, and Dr. Carmichael fail to document a history of a work accident. Furthermore, Petitioner reported to the Advocate BroMenn emergency room April 22, 2011 with complaints of discolored toes on her left foot. Once again, there is no indication Petitioner sustained an injury at work.

In addition to the foregoing, four medical depositions were submitted into evidence. Dr. Hanson provided treatment for Petitioner's left knee. He testified that within a reasonable degree of medical certainty, April 20, 2011 was not an accurate alleged date of accident. He further testified the cause of Petitioner's left knee problem was whatever she was doing before the MRI was performed on March 23, 2011.

Dr. Carmichael provided treatment for Petitioner's lower back. He testified he was not aware of any changes in Petitioner's condition, symptoms, anatomy, or pathology between April 13, 2011 and May 9, 2011.

Dr. James Kohlmann, an orthopedic surgeon, performed a record review, and he testified there was no causal relationship between Petitioner's job duties and either her low back or her left knee condition.

Dr. Lawrence Li performed an IME, and he testified he did not have any information either from Petitioner or from the medical records to suggest anything occurred April 20, 2011.

Based upon the foregoing and the record taken as a whole, The Arbitrator finds Petitioner failed to prove she sustained accidental injuries which arose out of and in the course of her employment for Respondent on April 20, 2011. Benefits are therefore denied. All other issues are moot.

With regard to 11 WC 33130, alleged accident date of March 17, 2011

Petitioner testified that other people were in the shop working, but she did not mention the incident that day to anyone, either to co-workers or to supervisors.

The Arbitrator notes, Petitioner's description of the mechanism of the injury to her knee was inconsistent. On direct examination, she testified she was holding a box, and when she twisted to the left to move it she heard a pop in her left knee. On cross examination, she testified the March 17, 2011 alleged accident occurred when she squatted down to pick up a box, and when she stood back up, she heard and felt a snap in her left knee.

The documentary evidence does not support Petitioner's alleged accident of March 17, 2011. PX6 is an "Employer's Basic Report of Injury." Only page 1 of 2 was offered by Petitioner. The "Date of injury" indicated is April 20, 2011. It indicates that the injury occurred when Petitioner was "sitting, standing & twisting" "in the process of normal activities" and suffered "torn ligaments in knee and bulging discs in back." There is no mention of a March date of injury. PX7 is is dated May 10, 2011 (more than 45 days after March 17, 2011). The date of accident listed is April 20, 2011. It indicates that "sometime during day while standing, sitting and twisting" in "normal activities" the Petitioner sustained "knee-torn ligaments/back three bulging discs." PX8 is dated May 11, 2011 (more than 45 days after March 17, 2011). It is signed by both Phil Wieland of the Respondent, and the Petitioner. The date of injury listed is April 20, 2011. It indicates the injury resulted from "prolonged sitting, standing and twisting while performing job duties", and affected the back and knee, with injuries listed of bulging discs and torn ligament. PX9 is a "Job Analysis". Only page 1 of 2 was provided

by the Petitioner. A date of injury of April 20, 2011 is listed. Although Petitioner testified to a particular incident occurring on March 17, 2011, there is nothing in these exhibits support that assertion. In fact, the documents directly contradict Petitioner's testimony.

The overwhelming weight of the medical evidence fails to support Petitioner's alleged accident of March 17, 2011.

Although Petitioner testified that when she saw Dr. Kube she told her about the left knee incident at work, the record from Dr. Kube's office visit on March 17, 2011 mentions left knee pain with locking, but absolutely nothing about a work incident, or any incident whatsoever. It mentions that the Petitioner is on her feet at work all day, but also states, "[t]here has been no recurrent injury." The April 7, 2011 record of Alicia High mentions left knee pain but absolutely nothing about a work incident, or any incident whatsoever. Dr. Kube's records of April 25, 2011 mentions left leg pain, red streaks and dark blue toes. The Assessment included Raynaud's phenomenon of the foot secondary to neurological disorder in the back. There is no mention in the record of a work incident, or any incident whatsoever. On April 28, 2011 Dr. Seibly noted low back pain and left lower extremity pain, worsening in the past three weeks. Patient has been unable to tolerate her job. There is no mention in the record of a work incident. Similarly, visits with medical providers on April 29, 2011, May 9, 2011, May 17, 2011, and July 12, 2011 contain no notation of any traumatic incident, work related, or otherwise. For the first time, on July 20, 2011, at McLean County Orthopedics, the record indicates that she had twisted it at work.

Dr. James Kohlmann testified he could find no record of a knee injury in the treatment notes. Dr. Kohlmann noted the 20 year history of low back problems, at times associated with left leg problems or pain, and an extremely comprehensive treatment program over those 20 years that failed to solve her back and leg pain problem. There was no injury or accident on record that could have caused her knee problem.

Dr. Lawrence Li examined the Petitioner for the Respondent in 11WC33130. He noted the many office visits before July 20, 2011 at which there was no mention of a work incident.

Dr. Carmichael was a treating doctor of the Petitioner's. He rendered no opinions concerning the Petitioner's left knee.

Dr. Hanson, a treating doctor, testified based upon a hypothetical question posed by Petitioner's attorney, which asked him to assume that on April 20, 2011 the Petitioner twisted and turned with a box weighing about 25 pounds and had some increased knee pain, that that could have caused or aggravated Petitioner's knee condition. However, that hypothetical is not consistent with Petitioner's testimony. Further, the Arbitrator finds that the doctor's response simply indicates that the mechanism of injury could be consistent. Dr. Hanson was also given a hypothetical question about a repetitive trauma claim based on the Petitioner's job duties. Again, an allegation of injury due to repetitive trauma is not the Petitioner's testimony that she injured herself in a single traumatic incident. Dr. Hanson has operated on the Petitioner's right knee as well as her left. The conditions were essentially the same.

With respect to notice, Petitioner is not sure when she told a supervisor about her knee. She does not even know the month when she first told a supervisor about her knee. She remembers being in Bill Frautschi's

office, speaking with Bill Frautschi and Phil Wieland. No forms were completed at that time. She proposed to Frautschi and Wieland that they put her on "temporary layoff", they refused, so Petitioner indicated she would file a workers' compensation claim. Petitioner testified that she was not sure whether she described how the left knee injury occurred during that meeting, or if she ever did.

In summary, Petitioner testified to a knee incident at work, all be it with conflicting testimony regarding the mechanism of injury, but was completely vague and non-committal as to when she told her employer and what she told her employer. The documentary evidence, some of which is signed by the Petitioner, makes no mention of a knee incident on or around March 17, 2011. The medical records are completely devoid of a knee incident, until late July, 2011.

Based upon the foregoing and the record taken as a whole, The Arbitrator finds Petitioner failed to prove she sustained accidental injuries which arose out of and in the course of her employment for Respondent on March 17, 2011, and further failed to prove she provided notice of any such alleged accidental injury within 45 days as required by the Act. Benefits are therefore denied. All other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wayne Harris Sr,
Petitioner,

vs.

NO: 16 WC 35711

State of Illinois/Pinkneyville Correctional Center ,
Respondent.

18IWCC0386

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, causal connection, permanent partial disability, employee/employer relationship 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 18, 2017, is hereby affirmed and adopted.

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

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

DATED: JUN 14 2018
o060718
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARRIS SR, WAYNE
Employee/Petitioner

Case# **16WC035711**

SOI/PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

18IWCC0386

On 12/18/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
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CARBONDALE, IL 62901

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

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

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

DEC 18 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Wayne Harris, Sr.
Employee/Petitioner

v.

State of Illinois/Pinckneyville Correctional Center
Employer/Respondent

Case # **16** WC **35711**

Consolidated cases: **n/a**

18IWCC0386

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **November 14, 2017.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 30, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

Petitioner's earnings during the year preceding the injury were **$62,388.00**, and the average weekly wage was that of **$1,199.77.**

On the date of accident, Petitioner was **64** years of age, ***married*** with **0** dependent children.

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

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

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 **$ all amounts paid under group health plan** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner failed to meet his burden of proving an employer-employee relationship existed between Petitioner and Respondent. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

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

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

Signature of Arbitrator

12/15/17
Date

DEC 18 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Wayne Harris, Sr.
Employee/Petitioner

Case # 16 WC 35711

v.

Consolidated cases: N/A

State of Illinois/Pinckneyville Correctional Center
Employer/Respondent

18IWCC0386

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is 65 years old and is retired. He testified that he was a correctional officer at the Illinois Department of Corrections before his retirement. Petitioner alleged that he suffered repetitive trauma to his bilateral hands due to his job duties with a manifestation date of September 30, 2016. (AX2).

Petitioner testified that he retired from Pinckneyville Correctional Center in November 2013. He testified that he started his career with the Illinois Department of Corrections (hereinafter "IDOC") in 1991 at Menard Correctional Center (hereinafter "Menard"). He testified that after working at Menard for eight years, he transferred to Pinckneyville Correctional Center (hereinafter "Pinckneyville"). He testified that during his eight years at Menard, he spent approximately 90% of his time as a wing or gallery officer. He further testified that he spent about 90% of his time at Pinckneyville as a gallery or wing officer. He testified that he reviewed the Corvel job analyses and agreed with those assessments.

Petitioner testified that he bar rapped daily at Menard. He testified that while bar rapping, he felt vibration in his hands and arms. He testified that the doors at Menard opened with Folger Adams keys and were not easy to open, that the doors were old and that the locks jammed. He testified that chuckholes were opened with a Folgers Adams key and then pulled down, and that that the doors were made from steel and were very heavy. He testified that after eight years at Menard his hands felt tired, stiff and sore. He further testified that he noticed this at the end of his shifts, but did not see a doctor at that time.

Petitioner testified that he worked in segregation at Pinckneyville. He testified that in segregation, services were rendered through a chuckhole which was opened with a Folger Adams key. He testified that there was no bar rapping. He testified that he performed wing checks. He testified that chuckholes were filthy because inmates stuck things in the locks. He also testified that he cuffed and uncuffed inmates.

Petitioner testified that his arms were sore and stiff when he retired in 2013. He testified that he thought it would go away by not doing his job anymore. He testified that he never saw a doctor regarding his hands and arms while working at Pinckneyville. He testified that after he retired from the IDOC, his hands and elbows did not improve and got worse. He testified that he then saw his primary care physician, who referred him to Dr. Alam for a nerve conduction study. He testified that he was diagnosed with carpal tunnel syndrome and ulnar tunnel problems. He testified that he then filled out an injury report.

Petitioner testified that he rides a motorcycle approximately 2,000-3,000 miles per year and that he gardens. He testified that he worked the 3 p.m.- 11 p.m. shift at Menard and the day shift at Pinckneyville.

Petitioner testified that his attorney referred him to Dr. Mall. He testified that he underwent surgery with Dr. Mall and that it helped. He testified that he still has some problems including his lower fingers going numb occasionally and that sometimes he gets a tremor. He testified that he also has loss of grip strength and loss of arm strength. He testified that it is now harder to cast when fishing and that he does not ride his motorcycle as much.

On cross examination, Petitioner testified that he began experiencing symptoms while working at Menard. He testified that he thought the symptoms he experienced in his hands were related to his job duties, but that one expected to have aches and pains when doing a job.

On cross examination, Petitioner testified that he locked and unlocked doors at least 300 times per shift at Menard. Petitioner admitted that when performing counts, officers could communicate with the inmates through the little window and did not always have to open the cell doors. He testified that counts were typically performed one time per shift. He also admitted that for mass line movements at Menard, there was a crank system that could be used to open all the cell doors instead of keying each individual door. He testified that inmates only had to be cuffed through the chuckhole in segregation at Menard.

On cross examination, Petitioner testified that he moved to Pinckneyville in 1999 and that he worked the 7 a.m. - 3 p.m. shift. He testified that there were only two cells at Pinckneyville that required bar rapping, which was performed once per shift. He testified that he locked and unlocked doors at least 300-500 times per shift at Pinckneyville. He admitted that the cell doors at Pinckneyville did not use a Folgers Adams key, but rather a key that was slightly larger than a house key. He testified that Pinckneyville was only one year old when he started working there. He testified that his job duties varied throughout the course of the day and that there were periods of rest in between doing different job duties.

On cross examination, Petitioner testified that he retired in November 2013 but that his symptoms continued to progress until he sought medical treatment three years later. He testified that he rode his motorcycle to work as often as he could and that he rode his motorcycle frequently. He testified that after his retirement, he spent more time on his hobbies, including fishing, hunting and gardening. He testified that he is currently 65 years old and has been diagnosed with hypertension.

On cross examination, Petitioner testified that after his surgeries were performed, the last time he saw Dr. Mall was on March 6, 2017. He testified that Dr. Mall told him to return in four weeks, but that if he was doing okay he could just call. He testified that he called and indicated that he was doing okay. He testified that Dr. Mall told him that he should return if he had any additional problems and that he has not done so. He testified that he did not do any formal physical therapy. He testified that he does not have to wear any kind of brace or protective device. He testified that he does not take any prescription medication for his elbows or wrists, but that he does take Tylenol.

Petitioner called Major Anita Ramsey as a witness at the time of arbitration. Major Ramsey testified that she has been employed at Pinckneyville since 1998. She testified that she had worked with Petitioner at Pinckneyville and that she was his direct supervisor on several occasions. She testified that she disagreed with Petitioner's testimony that he opened doors over 300 times a day. She testified that she would estimate the door opening at 60-80 times per shift. She testified that you would only use a key to open the doors if there was not a mass line movement. She further testified that there were no bars in segregation at Pinckneyville and that the only bars were in the shower unit.

On cross examination, Major Ramsey testified that the type of key used to open doors at Pinckneyville was not a Folger Adams key but rather a key that was slightly larger than a house key. She

testified that the cell doors at Pinckneyville opened easily as it was still a fairly new facility. She testified that you could open a door at Pinckneyville using only two fingers.

Petitioner called Major Terry Grissom as a witness at the time of arbitration. Major Grissom testified that he is employed by the IDOC at Shawnee Correctional Center. He testified that he previously worked at Menard. He testified that based on his experience, the Corvel job analysis indicating that an officer turned his wrist up to 5½ hours per day was high. He testified that it was his experience that an officer would not have to lift over 25 pounds on a regular basis. He testified that Menard was on lockdown often in the 90's and that during that time, correctional officers would carry the laundry, trash, mail and food and would also perform cleaning.

On cross examination, Major Grissom testified that a correctional officer would open and close doors around 50-80 times per shift at Menard. He testified that a correctional officer's job duties would vary throughout the day and that there would be intermittent rest between doing the different duties.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Rea Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on September 28, 2016, at which time it was noted that he was seen for right arm pain. It was noted that Petitioner had right elbow pain that he described as aching, that he had morning stiffness for greater than 30 minutes, that he had radiation of pain to the arm and that his range of motion was limited. It was noted that Petitioner had numbness and tingling intermittently in the bilateral hands, right greater than left, and that exacerbating factors included extension of the elbow. The Review of Systems noted that Petitioner stated that he had been having right arm pain for about a month and that he stated that it started in his shoulder and had moved into the elbow and hand. The assessment was noted to be that of (1) right elbow pain; (2) pain of right arm; (3) pain of left arm; (4) paresthesia of skin. Petitioner was recommended to undergo x-rays of the right elbow for suspected osteoarthritis. Petitioner was also recommended to undergo nerve conduction studies of the bilateral upper extremities. (PX3).

The records of Rea Clinic reflect that Petitioner was seen on October 27, 2016, at which time it was noted that he stated that he had significant tingling, numb pain in his hands and elbows, especially in digits 4 and 5 bilaterally. It was noted that Petitioner stated that he continued to have his low back and joint pain, all of which was controlled with his Norco effectively. The assessment was noted to include (1) essential hypertension; (2) chronic obstructive pulmonary disease; (3) anxiety associated with depression; (4) GERD; (5) benign prostatic hyperplasia with lower urinary tract symptoms; (6) bilateral low back pain with sciatica presence; (7) primary osteoarthritis involving multiple joints; (8) carpal tunnel syndrome; (9) cubital tunnel syndrome; (10) migraine with aura. Petitioner was instructed to continue with Orthopedics as directed. Included within the records of Rea Clinic was an interpretive report for x-rays of the right elbow taken on September 28, 2016 at Marshall Browning Hospital, which were interpreted as revealing extensive arthritis and bony hypertrophy. (PX3).

The medical records of Marshall Browning Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent pre-operative chest x-rays on January 30, 2017. (PX4).

The medical records of Dr. Fakhre Alam were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent an EMG/Nerve Conduction Study on September 30, 2016, which was interpreted as revealing (1) moderately severe bilateral ulnar neuropathy at the elbow; (2) moderately severe bilateral carpal tunnel syndrome, left worse than right; (3) no evidence of cervical radiculopathy on either side. (PX5).

The medical records of Dr. Nathan Mall were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on November 3, 2016, at which time it was noted that his chief complaint was that of bilateral upper extremity complaints. It was noted that Petitioner was a former employee of the Department of Corrections and that he retired from his position in November of 2013. It was noted that Petitioner stated that at the time while working for the Department of Corrections, he had developed some numbness and tingling in his hands, that he thought that this was somewhat part of the job and that he did not really think much of it. It was noted that Petitioner's symptoms had continued to progress and that he began seeking treatment in September of 2016. It was noted that Petitioner saw his primary care physician, that an EMG/nerve conduction study was ordered and that he was then sent to Dr. Mall for evaluation and treatment of his upper extremity conditions. The assessment was noted to be that of (1) bilateral carpal tunnel syndrome; (2) bilateral cubital tunnel syndrome; (3) bilateral CMC joint arthritis; (4) bilateral elbow arthritis. It was noted that Petitioner was recommended cortisone injections into both elbows, that he was recommended night bracing for his bilateral wrists and elbows and that he was also recommended anti-inflammatory medication but that he could not take it due to his lung condition. Injections were performed in the elbows on that date. (PX6).

The records of Dr. Mall reflect that Petitioner was seen on December 16, 2016, at which time it was noted that he continued to have some numbness and tingling in his bilateral upper extremities. It was noted that Petitioner continued to have some pain at the wrist and the elbow level as well and that he had numbness and tingling in both the median and ulnar distributions of his bilateral upper extremities. The assessment was noted to be that of (1) bilateral carpal tunnel syndrome; (2) bilateral cubital tunnel syndrome; (3) bilateral CMC joint arthritis; (4) bilateral elbow arthritis. Petitioner was recommended to proceed with carpal tunnel releases and cubital tunnel decompression with ulnar nerve transposition. At the time of the March 6, 2017 visit, it was noted that Petitioner underwent carpal tunnel and cubital tunnel release on the left side as well as on the right side previously and that he was being seen for his first post-operative visit for the left side. It was noted that Petitioner's incisions were healing nicely, that there was no evidence of infection, that he had intact sensation and motor function in all nerve distributions and that his numbness and tingling were gone in the bilateral upper extremities. Petitioner was recommended to start using his upper extremities as aggressively as he would like. It was noted that Petitioner was to return in four weeks' time or on as as-needed basis as he came from a long distance. (PX6).

The medical records of Timberlake Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent (1) left carpal tunnel release and (2) left cubital tunnel nerve decompression and transposition by Dr. Mall on February 20, 2017 for pre- and post-operative diagnoses of left carpal tunnel syndrome and left cubital tunnel syndrome. The records reflect that Petitioner underwent (1) right carpal tunnel release and (2) right cubital tunnel nerve decompression and transposition by Dr. Mall on February 6, 2017 for pre- and post-operative diagnoses of right carpal tunnel syndrome and right cubital tunnel syndrome. (PX7).

The transcript of the deposition of Dr. Nathan Mall was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Dr. Mall testified that he is an orthopedic surgeon whose practice consists of approximately 80% of cases involving the shoulder and knee and 20% of cases involving the elbow and hand as well as ankle and hip injuries. He testified that he is board-certified. (PX8).

Dr. Mall testified that he first saw Petitioner on November 3, 2016 and that he was referred to him by Mr. Rich's office. He testified that he was also sent various materials regarding Petitioner's employment that he reviewed, including the Menard Correctional Center correctional officer video, the post description of a cell house officer at Menard Correctional Center and a Demands of the Job form prepared by the State of Illinois, among others. He testified that Petitioner gave him a history of his work activity, which included his having worked for the Department of Corrections, that he retired in November of 2013, that he was having some numbness and tingling in his hands at that point and that since retiring, his symptoms got

somewhat better but still persisted and caused him to get medical treatment. He testified that Petitioner worked at Menard for a period of time as well as at Pinckneyville. (PX8).

Dr. Mall testified that the physical examination revealed that Petitioner had pain will full extension and full flexion of his elbows, that he had mild pain with palpation over the radiocapitellar joint in the elbow, that he had pain and numbness in the ulnar distribution with palpation of the medial epicondyle and ulnar groove, that he had positive flexion-compression tests at both elbows, that he had positive Tinel's at both elbows, that he had some mild pain over the CMC joints of both thumbs, that he had positive flexion-compression tests at both wrists and that he had positive Tinel's at both wrists for carpal tunnel syndrome. He testified that he was aware that the nerve conduction studies that were ordered by Petitioner's primary care physician demonstrated bilateral carpal and cubital tunnel syndrome. (PX8).

Dr. Mall testified that he reached a diagnosis of bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, bilateral CMC joint arthritis and bilateral elbow arthritis. He testified that various risk factors for carpal tunnel syndrome included obesity, hypertension, diabetes, gender and age. He testified that Petitioner was mildly obese, that his blood pressure was elevated and that he was of advanced age. He testified that he recommended night bracing for Petitioner's wrists and elbows and that they discussed doing cortisone injections into the elbows. He testified that he next saw Petitioner on December 16, 2016, at which time he continued to have numbness and tingling, pain at the wrist and elbow and numbness and tingling in both the median and ulnar distributions. He testified that Petitioner did not improve with conservative treatment and that he recommended a carpal tunnel release and a cubital tunnel decompression with an ulnar nerve transposition, which were performed. He testified that intraoperatively, he did not discover any arthritic changes in the areas where he operated. (PX8).

Dr. Mall testified that the majority of Petitioner's arthritis in his elbow was at the radiocapitellar joint, which was the lateral side of the elbow and not the medial side where the ulnar nerve is located. He testified that as to the wrist, it was at the CMC joint. He testified that CMC joint arthritis could have a little bit of an effect on Petitioner's bilateral carpal tunnel and cubital tunnel syndromes, but that his was not severe to the point where he needed to have a surgery for his CMC joint arthritis. He testified that Petitioner had done great following surgery and that he was seen again on March 6, 2017 following the surgeries. He testified that Petitioner's numbness and tingling had resolved, that he was very happy and that he was sleeping at night. He testified that he scheduled Petitioner to return in four weeks' time and that since he was coming from such a far distance, he could call and that he did not have to see him if he was doing fine. (PX8).

Dr. Mall testified that Petitioner noted that there was some improvement when he stopped working but that it just never completely went away. He testified that he thought that this was because Petitioner's nerve was damaged to the point where it was not going to get better fully. He testified that he encouraged individuals to get treated right away because the best chance at treating someone conservatively was to treat them before the symptoms had persisted for an extended period. (PX8).

Dr. Mall testified that it was his opinion that Petitioner's work duties as a correctional officer for Menard for 8 years and his job duties at Pinckneyville for 14 years were at least a significant risk factor for Petitioner and led to the development of his conditions. He testified that if Petitioner were to testify that 90% of his time at Menard and 90% of his time at Pinckneyville was spent on the gallery, he believed that this further bolstered his opinion on causation that Petitioner's job duties either caused or contributed to his condition and need for treatment. (PX8).

On cross examination, Dr. Mall testified that he did not have a certificate of added qualification for hand surgery. He testified that the only medical records that he reviewed outside of his own were the EMG/nerve conduction studies. He testified that he did not review Petitioner's notice of injury. He testified that he did not have any document from the facility outlining what different assignments Petitioner had in

his tenure with the IDOC. He testified that he did not know what shift Petitioner worked before he retired at Pinckneyville nor did he know what shift he worked at Menard. He testified that he did not know what staff assignments Petitioner worked at Menard. (PX8).

On cross examination, Dr. Mall testified that his causation opinion was based on Petitioner's job duties at both Menard and Pinckneyville. He testified that it was the grip as well as the position of the wrist involved in Petitioner's job duties such as bar rapping, turning the heavier keys and using the key to turn the handcuffs off that could lead to the development of carpal and cubital tunnel syndrome. He testified that he did not know the number of cells at Pinckneyville that had chuckholes. He testified that he believed it was the case that there were specific areas that had chuckholes while others did not. He testified that he did not know how many staff assignments there were at Pinckneyville. He testified that he did not believe that Petitioner's duties as a control officer contributed to the development of carpal and cubital tunnel syndrome. (PX8).

On cross examination, Dr. Mall testified that he had not been to either Pinckneyville or Menard. He testified that he has not cuffed or uncuffed a person with IDOC handcuffs. He testified that he had not pulled on a cell door at an IDOC facility. He testified that he had not performed any key turning with any kind of key at an IDOC facility. He testified that he thought that Petitioner had to do bar rapping at both facilities but that he did not go into detail with him about how often he had to do this per shift nor did he say how long it took to do bar rapping. He testified that he did not know how many cells that Petitioner would be required to bar rap and that he did not know if bar rapping was done on every shift. He testified that Petitioner indicated in his job description that he had to lock and unlock doors at least 500 times per shift at Menard and that he believed he said about 300 times per shift at Pinckneyville. He testified that he assumed that it would depend on what Petitioner's shift assignment was for the day. (PX8).

On cross examination, Dr. Mall testified that he thought that the amount of force needed to lock and lock the doors at Menard varied depending on the type of door, whether or not the door was stuck and how much one had to "jiggle" it to get it to work. When asked if he knew what kind of keys were used at Pinckneyville, Dr. Mall responded that they were larger than standard keys but that he did not know if they were as big as the Folger Adams keys. He testified that he did not know when Pinckneyville opened. He testified that he did not know how often Petitioner had to open and close cell doors. He testified that many people had told him that the doors were hard to open at Menard and that those people were patients of his. He agreed that his knowledge of the doors sticking was based on what his patients told him. He testified that he had heard the same thing at Pinckneyville as well and that this was based on what his patients had told him as well as the videos that he had seen. (PX8).

On cross examination, Dr. Mall testified that he did not have the specific numbers as to how often cell checks were done at Menard nor did he know how often they were done at Pinckneyville. He testified that he assumed that cell checks were done on every shift, but that he did not know for sure. He testified that he assumed that the number of individuals Petitioner was cuffing and uncuffing per shift at Menard varied on a day-to-day basis but that he did not have the specific numbers, and that his answer would be the same for Pinckneyville as well. He testified that Petitioner did not indicate to him how many times he lifted items per shift nor did he indicate how much the items he lifted weighed. He testified that he believed that Petitioner reported to him that he worked in segregation at Menard but that he was not sure that he reported to him that he worked on the tactical team at Menard. He testified that he believed that Petitioner reported to him that he worked in segregation at Pinckneyville but that he was not sure that he reported to him that he worked on the tactical team at Pinckneyville. (PX8).

On cross examination, Dr. Mall testified that Petitioner indicated to him that he typically worked 37½ hours per week so he did not assume that he worked overtime at Menard frequently. He testified that Petitioner did not write in his job description if he did any overtime. When asked if he knew how much or how often Menard was on lockdown while Petitioner was there, Dr. Mall responded that he was sure that it

varied but that he did not know the answer. He testified that he did not know how often Pinckneyville was on lockdown while Petitioner was there either. (PX8).

On cross examination, Dr. Mall agreed that his causation opinion was based on Petitioner's accounts of his job duties to him when he spoke with him, those in the job description and his review of the materials regarding Menard and Pinckneyville. He agreed that a causation opinion was only as good as the history given. He agreed that if Petitioner's description of the job duties that he performed was inaccurate, that it could change his opinion. (PX8).

On cross examination, Dr. Mall agreed that carpal and cubital tunnel syndrome could both develop idiopathically. He agreed that Petitioner's age of 64 was considered a risk factor for the development of carpal and cubital tunnel syndrome. He agreed that Petitioner's increased body mass index was a risk factor for the development of carpal and cubital tunnel syndrome. He testified that Petitioner's hypertension was not a "huge" risk factor. He testified that Petitioner indicated to him that his hobbies included gardening and having a motorcycle. When asked if working with some gardening tools could cause or aggravate carpal tunnel syndrome, Dr. Mall responded that it depended on what tools and how much Petitioner was doing it. He testified that Petitioner did not give him the specific amount of time that he spent gardening. He testified that he was sure Petitioner had ridden his motorcycle since he had retired, but that he did not know how much. (PX8).

The July 27, 2017 IME Report of Dr. Williams was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The report reflects that Petitioner was seen on July 27, 2017, at which time it was noted that he was a 65-year-old right-hand dominant man who had worked as a correctional officer, that he was hired on December 9, 1991 and that he last worked in November of 2013, at which time he retired. It was noted that Petitioner stated that he worked for Menard for approximately 8 years and that he also worked at Pinckneyville, that he worked full time and that he said at Menard he worked with cell doors that stuck. It was noted that Petitioner stated that he used large and small Folger Adams keys, that he stated that he did bar rapping one time per shift and not on all assignments and that he stated that he was not sure exactly how long he was on a given rotation at a time and how long they switched rotations. It was noted that Petitioner also worked a double gate, that he stated he would have to slam doors for them to shut and that he also stated that he then worked at Pinckneyville doing the same job duties for 14-15 years. It was noted that Petitioner stated that the locks wore out, that he would have times in which the keys would stick and the doors would stick and that he stated that about a year after starting at Menard, he had numbness and tingling in his hands. It was noted that Petitioner stated that his first assignment involved a lot of working on the double gate, that he said he had had no numbness or tingling prior to working at Menard and that he thought when he retired it would get better but that it just got worse. It was noted that Petitioner had waking at night from sleep, that he had pain and numbness and tingling, that he had weakness and that he denied dropping anything. It was noted that Petitioner stated that all the fingers were numb on the right and left hands, that he stated that he underwent surgery in February 2017 for the right carpal and right cubital tunnel and that later he underwent a left carpal tunnel release and a left ulnar nerve decompression and transposition by Dr. Mall. It was noted that Petitioner's hobbies included fishing and gardening and that he rode a motorcycle for approximately 50 years. It was noted that Petitioner used to ride to and from work in the summer which was about 12 miles, and that it would be about 6-7 months a year. (PX9).

The report reflects that Dr. Williams believed that Petitioner showed no observations of malingering or symptom magnification and that his behavior seemed to be appropriate. It was noted that the diagnosis was that of status post right carpal tunnel release, left carpal tunnel release, right ulnar nerve decompression with anterior transposition and left ulnar nerve decompression with anterior transposition, as well as carpometacarpal joint arthritis bilaterally and right and left elbow arthritis. It was noted that Dr. Williams believed that Petitioner had CMC arthritis on the right and left sides and that he also had elbow arthritis on the right and left sides. It was noted that Dr. Williams felt that Petitioner's work at Menard could at least have been aggravating in the development and worsening of his carpal and cubital tunnel

syndrome. It was noted that Dr. Williams opined that Petitioner's medical treatment to date had been reasonable and necessary and that no additional medical treatment was necessary. It was noted that Petitioner had done very well and needed no further treatment, and that he had reached maximum medical improvement at approximately six weeks following the right as well as the left surgeries. (PX9).

Petitioner's Written Job Description was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The Job Description Video – Menard Correctional Officer was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The February 8, 2011 Job Analysis – Menard was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The Post Description - Cellhouse Officer was entered into evidence at the time of arbitration as Petitioner's Exhibit 13.

The Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The form reflects that Petitioner reported that his last day worked was that of November 30, 2013 and that his date of injury or illness was that of September 30, 2016. It was noted that Petitioner starting having numbness, tingling and pain in both arms, that it was keeping him awake at night and that when he did sleep, it woke him up. It was noted that the body parts affected were that of both arms, elbows and wrists. The form was completed on October 31, 2016. (RX1).

The Illinois Form 45: Employer's First Report of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The form reflects that it was dated October 31, 2016, that the date and time of accident were noted to be that of September 30, 2016 at 8:00 a.m. and that Petitioner was just at home, that he injured both arms and wrists and that he started getting tingling, numb [*sic*] and pain. It was noted that the parts of the body affected were that of the wrists and hands. (RX2).

The IME Report of Dr. James Williams was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The report was duplicative of that as contained in Petitioner's Exhibit 9. (RX3; PX9).

CONCLUSIONS OF LAW

With respect to disputed issue (B) pertaining to whether an employer-employee relationship existed between the parties, the Arbitrator finds that Petitioner failed to meet his burden of proving an employer-employee relationship existed between Petitioner and Respondent at the time of the alleged accident.

The Arbitrator notes that Respondent disputed the existence of an employer/employee relationship on the grounds that Petitioner's manifestation of injury and the filing of his Application for Adjustment of Claim occurred following his retirement and that the case of *Anthony Ramos v. State of Illinois/Menard Correctional Center*, 12 I.W.C.C. 0224 (2012) was applicable. The Arbitrator finds, however, that while Petitioner is correct that it has been held that a repetitive trauma injury can manifest itself after the termination of employment, the case at bar is distinguishable.

The Arbitrator notes that in the cases cited by Petitioner which were that of *A.C. & S. v. Industrial Commission*, 710 N.E.2d 837 (1st Dist. 1999) and *Anthony Ramos v. State of Illinois/Menard Correctional Center*, 12 I.W.C.C. 0224 (2012), the claimants alleged a manifestation date shortly after their departure from their employment. In *A.C. & S.*, the claimant's manifestation date was only a few days after he was laid off by Respondent. The Commission held "The modern rule allows compensation even when an injury occurs at a time and place remote from the employment if its cause is something that occurs entirely within the time and place limits of employment." *A.C.& S*, 710 N.E. at 840. In *Ramos*, the claimant had worked until December 2009 when he retired. The claimant in *Ramos* alleged a manifestation date after his retirement, *i.e.*, July 7, 2010, which was approximately eight months later. In the case at bar, however, Petitioner is alleging a manifestation date almost three years after his time of retirement, which is

significantly distinguishable as compared to both the *A.C. & S.* and *Ramos* cases, where the manifestation dates were less than one year after the claimant left employment with their respective employer. In the case at hand, Petitioner alleges a manifestation date almost three years after his retirement, which is a significantly longer period of time than the established precedent.

The Commission has found that when a petitioner is claiming a repetitive trauma injury, the alleged date of accident is considered the manifestation date and can be determined several ways, including the date the employee requires medical treatment or the date a reasonable person plainly recognizes the injury and its relation to work activities. *Ramos*, citing *Vasquez v. Menard Corr. Ctr.* 2010 Ill. Work. Comp. LEXIS 886 and *Durand v. Indus. Comm'n*, 862 N.E.2d 918 (2007). The Arbitrator finds that it is unreasonable to extend the employee/employer relationship to Petitioner's manifestation date, which is nearly three years after Petitioner left the employ of Respondent. As a result of the foregoing, the Arbitrator finds that Petitioner failed to meet his burden of proving an employer-employee relationship existed between Petitioner and Respondent at the time of the alleged accident.

In light of the Arbitrator's finding that Petitioner failed to meet his burden of proving an employer-employee relationship existed between Petitioner and Respondent at the time of the alleged accident, all benefits are denied. The remaining issues of accident, causation, medical bills, average weekly wage and the nature and extent of Petitioner's injuries are moot, and the Arbitrator makes no conclusions as to those issues.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria R. Aguilar,

Petitioner,

vs. NO: 06 WC 43827

City of Chicago,

Respondent.

18IWCC0387

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, prospective medical care, permanent partial disability, and penalties & 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.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 59-year-old employee of Respondent, who described her job as a street sweeper/laborer. Petitioner graduated high school and went to Triton Community College and received a machine tool tech associates degree. She also had attended Malcolm X College but had not yet completed her studies for an associates degree for medical ultrasound. She had a pharmacy tech license. She went a year and a half in nursing school and is a CNA. Prior to working for Respondent, she had worked in the ER and the pain clinic at Hinsdale Hospital (secretarial and med tech type work) for about 3 years. Petitioner also previously worked for Borg-Warner for 25 years (press operator, QA). She read blueprints and learned how to use measuring tools and test steel. She left there because it was not what she wanted to do (the industry went down) so she decided to return to

school. She had also worked as a hairstylist and a pharmacy tech at Osco, Walgreen's, and Dominick's. Prior to Respondent she was in school and working part-time at Dominick's as a pharmacy tech. Petitioner started working for Respondent about June 21, 2006 in streets and san. She had a pre-employment physical at Mercy before she started working for Respondent. Her job at Respondent varied from sweeping, cleaning, shoveling, and using a machine to cut trees. She also picked up and emptied trash and trimmed trees. On the date of accident, July 13, 2006, Petitioner testified she was sweeping (push broom) different locations (State to Michigan). Petitioner stated prior to that day she had no pains, no headaches, no problems. She had a broom and a tray to pick up garbage; her shift that day was 2:00pm to 10:30pm. On that day she was walking and working at Balbo and State and there was a board with a hole underneath; no nails in it. One board had nails in it. When she stepped on the board she went down with both feet in the hole in the sidewalk as she had to continue her job sweeping. She stated the hole was large; big enough for a person to fall into; about 3 feet across and 4-5 feet deep. She stated she went straight down with both feet and the board went in with her. She indicated she saw the jagged cement edge going to hit her face and she turned to avoid it. She recalled her face hit the sidewalk on the left side and she saw stars. Petitioner stated that the next thing she knew there were 2 people pulling her out. She had lost consciousness. Petitioner stated after her fall she felt dizzy and could not get herself together. Petitioner stated that she was groggy and the Chicago Fire Department was called and took her to the UIC Hospital ER. Petitioner testified that she notified her supervisor, Mr. Pope, of the injury right away. Petitioner did eventually prepare an accident report (PX 1); she indicated the parts of her body injured when she fell into the hole; she had noted ear, head, back, shoulder, and ankle. She was conscious at the ER; they brought her on a board. She indicated x-rays were taken of her right arm and right foot, and a head CT. She was released from the ER after about 5 hours.

- Petitioner followed up at MercyWorks, Respondent's clinic, with complaints to her right shoulder, left ankle, head, face, and back; they did not treat her head, face, or back then. Petitioner had follow ups for treatment at MercyWorks July 13, 2006 through March 7, 2007. She saw Dr. Patel there but she did not think he took her complaints seriously. The doctor gave her pain pills. Petitioner was eventually referred to Dr. Makowiec at MercyWorks for her right shoulder complaints about October 23, 2006. The next doctor she saw was Dr. Shepard at Lakeshore Medical Associates about October 14, 2006 (Northwestern gave her his name). She treated with Shepard, for dizziness, to about February 2007. Petitioner testified that Dr. Shepard sent her to different doctors for pain and her different problems. When she was treating with Dr. Shepard she had dizziness and she would trip and go off balance. Petitioner stated that she had a lot of pain and could not sleep due to cramps in her right leg. She said that she would lose strength in her feet and that her pain was severe. She treated with Dr. Makowiec regarding her right shoulder at Mercy (on referral per Petitioner). Dr. Makowiec performed some testing on her shoulder, including an MRI, and eventually recommended shoulder surgery which was done at Northwestern Hospital June 29, 2007. Petitioner went to Accelerated Rehab, on referral from the doctor, after surgery on her right shoulder for rehabilitation from about 7/24/07 to 11/16/07. Dr. Makowiec only treated her right shoulder. Petitioner indicated while she was treating for her shoulder she was having problems with other parts of her body. Petitioner stated that her right leg had a lot of swelling and pain. She stated it would fatigue.

She was also having problems with her head/neck/back. She stated she was dizzy and forgetful (would forget half of a conversation that she just had) and she had a lot of pain in the back of her neck, ear and jaw. Her ankle would swell and she could not even put on a shoe. Petitioner mentioned that to Dr. Shepard and he referred her to Dr. Krevitz, a podiatrist. She saw Dr. Krevitz, for her right ankle, between October 13, 2006 and August 23, 2007 at Northwestern Faculty Foundation. She was sent for therapy at ATI. Dr. Krevitz did not recommend surgery on her ankle. Petitioner indicated that the care was not helping and the pain came back when his care was concluded. She still had the leg pain and cramping in her feet. Petitioner testified that she sought a 2nd opinion with Dr. George Holmes, an ankle specialist at Midwest Orthopedics, on May 6, 2008. Petitioner stated Dr. Holmes did nerve testing on her ankle and wanted her to undergo physical therapy and other testing; however, she did not have physical therapy. Petitioner only saw Dr. Holmes on three occasions but the doctor did not know what was wrong. Petitioner was still treating with Dr. Shepard (neurosurgeon) at that time. Dr. Shepard treated her for headache, neck pain, jaw locking, and vision issues from a neuro perspective. Petitioner indicated the doctor referred her to different specialists to rule out causes of her problems. She had been referred to Dr. Christian Stevoff at Northwestern Medical Faculty whom she saw on December 6, 2007. Doctor Stevoff wanted to redo testing on her leg and performed a gastrointestinal examination to assess Petitioner's stomach complaints. Petitioner testified that Dr. Shepard also referred her to Dr. Soree, a general practitioner, whom she saw between December 4, 2006 and March 2, 2007. Petitioner was also seen by Dr. Fetterman (eye doctor) at Northwestern for blurred vision, on referral from Dr. Shepard. Petitioner testified that she went to the Rehabilitation Institute of Chicago (RIC) on referral from Dr. Makowiec between January 3, 2008 and February 2, 2009. She had a problem with the frontal part of her head.

- Petitioner testified that after the accident she had problems with memory loss, fatigue, eyesight at times, and speech problems. She indicated that RIC was trying to teach her to do one thing at a time as she wanted to perform as before the accident. She had been treated for a post-concussion head injury at RIC with Dr. Andrea Fraley. At Respondent's request Petitioner was examined at MercyWorks by Dr. William Heller in October 2006. Petitioner testified that Dr. Heller examined her right shoulder and her entire right side. She testified she was referred by Dr. Shepard to Dr. Pasulka whom she saw on 2 occasions, May 24 and June 15, 2007 for testing with numbers, reading and writing. Petitioner stated that Dr. Pasulka recommended some rehab. Petitioner eventually had psych rehab treatment at Loyola as she could not drive and Loyola was close to her house and recommended. She saw Dr. Reisman (February 27, 2008), a psychologist, who treated her for depression. Petitioner was still having problems with her right ankle and the whole right side of her body so she sought a second opinion with Dr. Armen Kelikian (own choice) for her right ankle. Petitioner stated that she treated with him from September 16, 2008 through April 23, 2009. Dr. Kelikian recommended surgery to clean it out as she was getting a lot of swelling. Petitioner received an injection initially and Dr. Kelikian recommended surgery about October 26, 2008. Surgery was performed at Northwestern on December 5, 2008 to release scar tissue and remove a ganglion. Petitioner was in a short cast after surgery for about 4 weeks and then had 6 weeks of therapy at Accelerated before eventually being discharged from Dr. Kelikian about April 23, 2009. Petitioner stated the surgery relieved

some of her ankle pain and swelling, so it was better. Petitioner saw Dr. Yallia Prasada at the request of her union as she is diabetic and her counts were high after the accident and not controlled; the cause was unknown. Dr. Prasada gave Petitioner pain medication and wanted to give her a shot to her ankle for her pain. Petitioner saw him 2-3 times. Dr. Prasada referred Petitioner to Dr. Yallapragada for her depression and anxiety. She saw Dr. Gulati, a neurologist, 2-3 times. Dr. Gulati conducted a brain scan and treated Petitioner's head, anxiety and leg pains from the accident. Petitioner last treated with Dr. Gulati in about 2009. Petitioner testified she was still having problems with her back at that time and no one had treated that while she was with the other doctors; they treated more her leg and ankle pain. Petitioner came under care of Dr. Vankatesan, a home care provider. Petitioner stated that he was like her Medicare doctor for home care and treated her at home only. Petitioner treated with him starting October 28, 2009 and was still treating with him at the time of hearing. She indicated he treated her whole body. Dr. Vankatesan sent her for therapy (at Scope, 11/10/09 - 2/2/10) and treated her back with bio-freeze. The doctor still came to her home weekly, unless needed sooner. She did have a lumbar MRI at Hinsdale Hospital. Dr. Vankatesan monitors Petitioner's diabetes and cares for her low back. She does do exercises at home; her body aches all the time. She stated she had been on a lot of pain pills and did not want to take so many.

- Petitioner saw Dr. Singh at Rush, at Respondent's request, for an IME regarding her back shoulder and ankle. She had treated at Mercy with several doctors for pain, depression, and head injury. She was last seen at Mercy about 3/07. Petitioner was off work 7/14/06 - 7/24/06 and then Respondent provided her with light duty job in a trailer watching the property where they kept the salt. Petitioner also had to answer phones. She worked that job until about 6/27/07 when she underwent surgery with Dr. Makowiec. She tried returning to work after surgery but they wanted 100% so she had not returned to light duty since. She had contacted Respondent about 3 times regarding light duty; first about 1/29/08 when the doctor released her. She was told they had a job with restrictions but they did not give her a job. She tried again 5/08 with the same result and again 8/08. She understood they did not want her back until she was 100%. Petitioner testified that she had looked for work since, with her medical background, but had been turned down by the many she tried (more than a dozen). Before she went out at least once a week. She knew what she could and could not do so she could not accept a job with what she did not think she could do. She was still under care of Dr. Vankatesan who had not released her to work due to her low back injury. She indicated the doctor was concerned she would never return to work.

- Petitioner indicated she was not as sharp mentally as before and she has a lot of anxiety. She has problems with planning and housework and cannot shop, walk or drive like before. She gets cramps while driving. She still has a driver's license but has not driven since the accident as she is afraid. She stated she has blurred vision and did not feel safe driving. She had surgery on her right shoulder and she does not have the strength; she gets fatigued and has pain on her right side. Her right ankle is still weak. With her back she cannot pick up anything heavy. She stated that she has a lot of pain from her left side to her right hip and down her legs: she never had that before the accident. Petitioner stated that to relieve the pain she exercises, bathes, and takes pain pills. She had no new injuries since the accident. She agreed she had therapy at ATI, Accelerated Rehab, Loyola, and Scope. She finished

therapy at Scope February 2010. She was still not working anywhere. She has looked but no one has offered her a job. Petitioner stated that she has incurred medical bills as a result of the accident.

- Petitioner testified previously before Arbitrator Hagan in 2010. At hearing before Arbitrator Gale, Petitioner testified to having had no additional accidents involving the same parts of her body since the 2010 hearing. She stated that she continued to suffer from the same problems she previously testified of. She was still suffering from headaches, confusion, anger, anxiety. She still did not sleep well and had a lot of pain and cramps. Her body tires from the pain daily and she does not know how bad it will be. She has received medical care since then at Loyola (through 1/10/12 for leg and right arm). She stated she had pain all over her body but her right side was worse; it started with the accident. She stated it all changed her life. She stated she had a lot of swelling and the pain. She stated her arm swells and she loses grip. She had a neuro consult and had treatment. She had a pain consult to deal with the pain. She had depression and anxiety and medication was recommended. She had a psych consult and therapy for her whole body at Loyola. She had no additional surgery. Petitioner wasn't sure if she was referred to Loyola by Dr. Shepard or another doctor. Petitioner sought care at Marianjoy in Oak Brook (3/29/12 - 11/29/12) after Loyola. Petitioner stated that she was referred there by Loyola. Petitioner stated that she received treatment for her back there as she walked off center. She also received physical therapy and pain management there. She went to another Marianjoy facility in Wheaton (5/20/14 - 7/2/14) after Oak Brook. She sought additional treatment as she was dealing with a lot of anger which came from the accident. She was under care of Dr. Padalik, a neuropsychologist, who did testing and a workup. She stated that she was seen there for pain and memory loss. She stated she had blurred vision and right ear problems. She testified that the treatment at both Marianjoy facilities had helped. Petitioner stated that the pain had not gone away and she had been to MacNeal Hospital a month before hearing. Petitioner stated that she always has pain and always seeks help. She was on pain pills regularly for nerves, anger and anxiety. She indicated she tried not to take a lot of medication and control it as they taught her. Petitioner testified that she has neither worked nor looked for work since the last hearing. She was currently on social security retirement.

- Petitioner testified that currently she has the same body pains if not more than before. She indicated that she learned how to control it without a lot of anxiety. She stated her right ankle swells at the end of the day; she cannot overdo it, she has to take her time. She noted pain sitting and her posture is not like before. She stated she had to learn how to work with what she has. She stated that she had low back pain that went down her right leg. She noticed weakness in her hands and less movement. She had a lot of memory loss. She stated that she hit cars as she cannot tell distance; depth perception off. Bending hurts her back and she had weakness. She had vision and ear problems. Her right ear hurts. She stated that she has a caregiver who helps her with daily things (he drove her to the hearing). Her son and daughter-in-law help at night. She testified she had incurred medical bills as result of treatment, some of which were paid via Medicare. She indicated she was one big hurt all the time.

The Commission finds that there is no real question that Petitioner suffered causally related injuries after falling into the hole. Petitioner did have prior low back complaints as well as a total knee replacement, contrary to Petitioner's testimony of no real prior leg or back issues. Petitioner had normal head diagnostics and Neuropsychological evaluations indicated that symptom complaints were variable and basically inconsistent with accident, as would be expected with such type or trauma. Petitioner saw multiple doctors (dozens, for various complaints/symptoms). Although there were some apparent referrals, it is not clear how/why she went to many of the various doctors other than for subjective pain complaints (10/10 pain all over) as indicated in her neuropsychological evaluation (questioning symptom magnification, exaggeration, psychosomatic, symptoms out of proportion). Petitioner's back, neck, and leg/ankle complaints as well as her head/psychological ('PTSD') complaints are not supported as arising from an accident or causally related to the accident with treatment from the various doctors for '2nd+' opinions scattered over many years. Petitioner's leg/ankle, low back complaints per Dr. Holmes, appear to have manifested secondary to her prior right total knee replacement, and that opinion seems more supported in the records in evidence. Petitioner's arm/shoulder complaints and ultimate surgery follow a reasonable causal chain of events related to the accident from which she had reached maximum medical improvement (MMI) and released to full duty on November 6, 2007. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence; Petitioner suffered an injury/accident only relative to her arm/shoulder, and, herein, affirms and adopts the Arbitrator's finding as to causal connection for the right shoulder/arm. Petitioner failed to prove accident/causal connection regarding her other claimed injuries.

The Commission, with the above findings of no accident/causal connection (CC) regarding the other parts of the body complained of finds the decision of the Arbitrator to deny TTD regarding the right arm/shoulder after the MMI date of November 6, 2007 supported in the evidence and testimony. 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. No further TTD benefits due and owing as Respondent has paid TTD and other benefits.

The Commission, with the above findings of no accident/CC regarding other parts of the body complained of finds the decision of the Arbitrator to deny any medical expenses regarding the right arm/shoulder after the MMI date of November 6, 2007 supported in the evidence and testimony. 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. Respondent entitled to credit for medical paid and no further or future medical awarded.

The Commission, with the above findings of no accident/CC regarding the other parts of the body complained of finds the decision of the Arbitrator supported in the evidence and testimony in so far as Petitioner having proven entitlement to a permanency award. The Commission finds, however, that the Arbitrator's award as to loss of the arm does not conform to current case law given Petitioner's shoulder injury and surgery. The appropriate award should be to the person as a whole. As such, the Commission finds Petitioner suffered a loss of 10% of her body as a whole (50 weeks at $390.36=$19,518.00). Furthermore, as the award goes to person as a whole,

18IWCC0387

Respondent is not entitled to credit for the prior right arm award. The Commission, herein, modifies the decision of the Arbitrator and finds Petitioner entitled to, and is awarded permanent partial disability of 10% loss of her person as a whole under Section 8(d)(2) of the Act.

The Commission finds that between the multiple doctors questioning what conditions were and were not related to Petitioner's accident and the credibility issues of Petitioner and the symptoms complained of was, Respondent had reason to question compensability all around. There was clearly nothing indicating vexatious or unreasonable Respondent behavior in denying compensation. Petitioner failed to prove entitlement to any such penalty against Respondent. 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $390.36 per week for a period of 50 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the loss of 10% of Petitioner's person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,700.00. 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 14 2018
o-4/19/18
DLG/jsf
045

David Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

AUGILAR, MARIA
Employee/Petitioner

Case# **06WC043827**

CITY OF CHICAGO
Employer/Respondent

18IWCC0387

On 8/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0748 LAW OFFICE OF STEVEN M SELAN
134 N LASALLE ST
SUITE 1720
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
WILLIAM O'BRIEN
140 S DEARBORN ST 7TH FL
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

Maria Aguilar
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **06** WC **43827**

Consolidated cases: _____

18IWCC0387

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **March 15, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 **Two-doctor rule**

18IWCC0387

FINDINGS

On **July 13, 2006**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$33,831.20**; the average weekly wage was **$650.60**.

On the date of accident, Petitioner was **58** years of age, ***single*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$20,406.82** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$12,000.00** for other benefits, for a total credit of **$32,406.82**.

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

ORDER

PPD awarded: Head/neck: zero, no causation opinion; Psychological: zero, her treater at Marianjoy said it was not related to accident; Right shoulder: 20% loss of use of the right arm, less the prior credit of 15% loss of use of the right arm = net of 5% loss of use of the right arm; Right ankle: zero, based on the opinion of Dr. George Holmes that her foot pain was related to her prior and unrelated total knee replacement and complete lack of causation opinion.

Petitioner is not entitled to any future TTD or medical benefits. Petitioner is not entitled to any past TTD benefits. Petitioner is not entitled to any past medical benefits as she failed to prove her treatment was causally related and/or within a proper chain of referrals under the Act. Petitioner failed to prove that she is permanently and totally disabled. Petitioner is not entitled to penalties and fees. Respondent is entitled to a credit for $32,406.82 as well as medical benefits already 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 J. Andros
Signature of Arbitrator

8-25-2017
Date

AUG 29 2017

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE WORKERS' COMPENSATION COMMISSION OF ILLINOIS

MARIA AGUILAR,)
)
Petitioner,)
) NO. 06 WC 43827
v.) Arbitrator Gale
)
CITY OF CHICAGO,)
)
Respondent.) 18IWCC0387

MEMORANDUM OF DECISION OF ARBITRATOR

Statement of Facts

Petitioner Maria Aguilar (hereinafter "Petitioner") worked for Respondent City of Chicago (hereinafter "Respondent"). The trial issues were accident, causation, past/future TTD, past/future medical, that Petitioner exceeded her two-choices of physicians, that she was permanently totally disabled, and whether penalties and fees are warranted. The parties agreed to an average weekly wage of $650.60. This yields a TTD rate of $433.73 and a PPD rate of $390.36. Petitioner is alleging injuries to her "entire body from a fall at work on July 1, 2006.

Medical

As testified to at trial there are approximately 48 – four dozen – treating physicians on this case. The parties submitted approximately 60 (combined) exhibits. For the purposes of judicial efficiency, Respondent will summarize the treatment by body part.

Right Foot/Ankle

On October 27, 2006, Petitioner had a right ankle MRI (per Dr. Alan Shepard Holmes). It showed tears of the anterior talofibular and calcaneofibular ligaments. Possible fracture of the cuboid. Ganglion in the anterolateral soft tissues. (Pet. Ex. 7)

She also saw a Dr. Crevitz, Dr. Lipinski, Dr. Dumanian, Dr. Kelickian and Mercy Works for her right ankle. For the sake of efficiency, Treatment routinely overlapped. The medical certainly do not provide any resemblances of a consistent chain of referrals, notwithstanding Petitioner's "unreliable history" testified to at trial.

On March 19, 2008, she eventually visited Dr. George Holmes. X-rays showed no ankle fracture. Per Dr. Holmes, Petitioner had a bone scan on March 31, 2008 that showed "mild increased activity along the plantar aspect of both calcanei and mild

uptake at the MTP joint of the great toes" – both sides, more on the left than the right. (Pet. Ex. 7)

On April 2, 2008, Dr. Holmes diagnosed bilateral foot pain. He noted the right ankle bone scan results do not correspond to her pain complaints. (Pet. Ex. 7)

At her last visit with Dr. Holmes on May 7, 2008 he opined he does "not have a good orthopedic explanation of her diffuse areas of pain." He continued that "*she may be having some of these right lower extremity manifestations secondary to her total knee replacement*." He noted the negative EMG and negative bone scan. No restrictions noted. She was to follow up as needed. (Pet. Ex. 7)

Five days after release by Dr. Holmes, she saw Dr. Lipinski on May 12, 2008. He was on board with Dr. Holmes in being unable to cite to the source of the right ankle problems as noted on May 12th, July 2nd and August 4, 2008.

On September 16, 2008, she began treatment with Dr. Armen Kelickian and Dr. Dumanian. Although an NCV was normal, she had right ankle surgery on December 4, 2008. She was released by Dr. Dumanian on May 6, 2009. No restrictions.

She then began treatment with Dr. Deen Venkatesen on October 28, 2009, in part for her ankle. At her trial in 2010, she testified that Dr. Venkatesen said she was permanently and totally disabled, in part because of her ankle. She then went on to say that she walks three miles per day.

Neck/Low Back

Petitioner testified at trial that she as part of her various injuries on July 13, 2006, she hurt her neck and low back. She expressly testified that she was certain that she never had low back treatment prior to the date of accident. The only consistent thing about Petitioner's medical records testimony and her trial testimony is that they are both equally inconsistent.

Petitioner repeatedly visited UIC for low back treatment with radiculopathy starting March 8, 2006. The symptoms were so bad that she required an MRI on March 9, 2006 which showed a disc bulge at L5-S1. A mere two weeks prior to the July 13, 2006 date of accident, on June 29, 2006 Petitioner was given a prescription for physical therapy to treat her symptoms. While hard to believe she said her low back, right knee and right lower extremity complaints all started when she injured herself slipping on a fork at work ***four years ago. What's more, she stated that she had no problems before this although in actuality, upon further questioning, she said she was told that she had a bulging disc even before her accident (four years ago)!!*** Res. Ex. 11

A lumbar spine EMG on April 2, 2008 was normal. To further evaluate Petitioner claim, Respondent obtained an IME with Dr. Kern Singh dated January 11, 2010. He diagnosed a strain with degenerative lumbar spondylosis. He noted it was degenerative and pre-existing in nature. It was not aggravated on July 13, 2006. He noted that she

(J) Were 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:

Petitioner is clearly excessively treating. She has been in constant treatment for her entire body for a decade. She's visited more than four dozen doctors and testified at trial that she has no intention of ceasing treatment any time soon, regardless of whether the treatment is causally related under the Act.

She is not entitled to any additional future medical benefits. Any unpaid past medical benefits incurred are not awarded as they are:

1. Unreasonable and unnecessary;
2. Not causally related;
3. Not within one of two chains of referrals under the Act.,

(K) Whether Petitioner is entitled to TTD, the Arbitrator finds:

Petitioner is not entitled to any TTD benefits other than what was already paid. Petitioner was released to return to work full duty for her right shoulder and right ankle. She received TTD until each date of MMI/full duty. There is no causation opinion linking the psychological/head/neck/low back injuries. There no lost time was paid or is owed.

(L) The nature and extent of the injuries, the Arbitrator finds:

Head/neck: zero, no causation opinion

Psychological: zero, her treater at Marianjoy said it was not related to accident.

Right shoulder: 20% loss of use of the right arm, less the prior credit of 15% loss of use of the right arm = net of 5% loss of use of the right arm.

Right ankle: zero, based on the opinion of Dr. George Holmes that her foot pain was related to her prior and unrelated total knee replacement and complete lack of causation opinion.

(M) Whether penalties and fees should be imposed, the Arbitrator finds the following:

The Arbitrator finds no merit to Petitioner's claim that Respondent was unreasonable and vexatious. This is based on 48+ different treating physicians providing inconsistent and unreliable opinions and results. On more than a dozen occasions, in the massive medical volumes, Petitioner was referred to a "poor historian". Petitioner has no causation opinion for her back or head/psychological issues, she was at MMI and full duty for her ankle then obtained a permanent total disability opinion, she was at MMI and full duty for her right shoulder only to treatment incessantly. Clearly, Respondent had a strong basis to deny the vast majority of her treatment and claim. No penalties and fees are warranted.

(N) Whether Respondent is due any credit, the Arbitrator finds the following:

was over-exagerating her pain scoring, at 10/10 with pain everywhere else. He was "extremely concerned" about symptom magnification. Res. Ex. 1.

Head/Psychological

Petitioner had three normal brain CTs: July 13, 2006, December 11, 2006, and August 28, 2007.

Petitioner was admitted to Marianjoy and evaluated by Dr. Eduardo Montoya as part of a neuropsychological exam. This evaluation took place on four separate occasions over the course of two months between May and July 2014. He reviewed Petitioner's entire treatment history of her psychological complaints since the date of accident of July 13, 2006. In summary, Dr. Montoya found that Petitioner had:

> "Emotional distress and cognitive complaints that were in excess of what would be expected and she had acknowledged and demonstrated significant anxiety throughout this evaluation. This is not related to neuropathology often found with individuals who have sustained a brain injury in nature, especially in consideration of her injury characteristics and her ability to improve her performances with increased demand of complex attention. Similar findings were indicated on her previous neuropsychological evaluation with Chris Randolph [in] (2011) in that her variable performances during cognitive assessment are most likely due to her emotional status in nature, but not likely due to brain injury as her performances were at or near expectation when compared to her premorbid academic and intellectual abilities. Her presentation is more consistent with her personality characteristics in that she has a propensity to develop physical symptoms in response to stress and demonstrate substantial irritability and somatic complaints."
>
> -Pet. Ex. 42, 43, 44

Right shoulder

On June 29, 2007, Petitioner had right shoulder surgery. It consisted of a right shoulder arthroscopy and arthroscopic rotator cuff repair, acromial decompression and debridement of old bony banker lesion. She was released to return to work full duty on November 6, 2007.

(C) & (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 accident, the Arbitrator finds the following:

While Petitioner's records and testimony appear to be consistent about the facts of the accident, that's the only consistency that the Arbitrator can speak of. There are clearly significant issues with the low back treatment causation, given the prior treatment and significant gaps in treatment. The head/psychological records to not support a finding of causation linking the claimed symptoms with the alleged injury.

The right shoulder is deemed related. The right ankle is not as renown foot orthopedic Dr. George Holmes related the injury to her prior right knee replacement.

Respondent is entitled to a credit for all TTD and medical benefits paid to date.

Petitioner's current date of accident is July 13, 2006. As part of her alleged complaints, she alleges a right shoulder injury. She had a prior right shoulder injury from a date of accident of January 30, 1981 (81 WC 32785). This case resolved for 15% loss of use of the right arm. Respondent is entitled to a credit for the 1981 case against the 2006 case as it precedes *Will County Forest Preserve*.

(O) Other issues:

Petitioner visited approximately four dozen treating physicians, the vast majority for which there is no evidence to support that they are within the two allotted chain of referrals, especially the right ankle surgery. Petitioner's exhibits clearly cannot substantiate all of these treaters. Additionally, Petitioner's testimony and ability to recall past events is extremely questionable – at best. Therefor any testimony to this issue is given zero weight by the Arbitrator. The Arbitrator finds that unless the records clearly provide a written referral, it cannot be said that Petitioner met her burden to show a chain allowed under the Act.

ARBITRATOR

DATED AND ENTERED

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

DAVID FINK,

Petitioner,

vs. NO: 12 WC 3215

A.C. MCCARTNEY FARM EQUIPMENT,

18IWCC0388

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical benefits, temporary total disability (TTD), nature and extent, and credits, 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 Respondent voluntarily waived its right to oral argument.

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 the testimony, exhibits, pleadings, and arguments submitted by the parties. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)).

For the reasons stated below, the Commission hereby vacates Petitioner's permanent and total disability benefits awarded pursuant to Section 8(f) of the Act, and awards Petitioner 50% loss of use of the person as whole under Section 8(d)2 of the Act.

The Arbitrator in this claim found that Petitioner was permanently and totally disabled (PTD) because there were no available jobs for Petitioner given his age, training, education, experience, and condition.

> [A] person is totally disabled when he is incapable of performing services except those for which there is no reasonably stable market. [Citation]. Conversely, an employee is not entitled to total and permanent disability compensation if he is qualified for and capable of obtaining gainful employment without serious risk to his health or life . . .
>
> [I]f the claimant'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*, the burden is upon the claimant to establish the unavailability of employment to a person in his circumstances. However, once the employee has initially established that he falls in what has been termed the 'odd-lot' category (one who, though not altogether incapacitated for work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market [Citation], then the burden shifts to the employer to show that some kind of suitable work is regularly and continuously available to the claimant. *Ceco Corp. v. Indus. Comm'n*, 95 Ill. 2d 278, 286-287 (1983).

Petitioner may satisfy his burden of proof in one of two ways:

> [B]y showing diligent but unsuccessful attempts to find work, or (2) by showing that, because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. [Citation]. Once a claimant establishes that he falls within an "odd lot" category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Sharwarko v. Ill. Workers' Comp. Comm'n*, 2015 IL App (1st) 131733WC ¶53.

In the case at bar, there is no medical evidence to support a claim of total disability. Petitioner's physician, Dr. Curtis Burton, had recommended restrictions of no lifting more than 10 pounds and no more than one hour of continuous standing at a time, three hours maximum standing in a day. (PX1). Dr. Burton also stated that Petitioner's restrictions of limited standing and limited flexibility in regards to both knees were permanent. (PX5; PX25). Respondent's Section 12 examiner opined that Petitioner could return to full duty work.

The Arbitrator found that Petitioner met his burden of proof under the "odd-lot" category because the vocational counselor, Lisa Helma, and the Social Security Administration determined that Petitioner was unable to return to his former duties for Respondent. The Arbitrator also relied on Ms. Helma's opinion that Petitioner had no skills that would transfer to any sedentary type jobs.

Ms. Helma had stated that based on the United States Department of Labor, "Sedentary unskilled occupations comprise of approximately 1% of the United States labor market." Thus, Ms. Helma believed Petitioner had lost access to his usual and customary line of occupation of Set-Up Mechanic and that his disability was total. (PX13).

As the Arbitrator believed that Petitioner met his burden of showing the unavailability of employment, the burden now shifted to Respondent to show that suitable work, that was regular and continuous, was available. The Arbitrator noted that Respondent at one point did accommodate Petitioner's restrictions for three months, but instead chose to rely on its Section 12 examiner's opinion that Petitioner could work without restriction. The Arbitrator indicated that at no time did Respondent do a vocational assessment or offer vocational rehabilitation. Thus, the Arbitrator found that Respondent failed to meet its burden and awarded PTD benefits pursuant to Section 8(f) of the Act.

Notwithstanding the Arbitrator's Decision, the Commission finds that Petitioner did not prove his entitlement to PTD benefits. The receipt of Social Security disability benefits does not stand as proof that Petitioner is entitled to PTD benefits. The standard of proof for such an award is outlined in the above paragraphs.

Petitioner did not show "diligent but unsuccessful attempts to find work." He testified that he searched for work for approximately 20 weeks, and that he found "two employers that would probably have hired me if I didn't have bad knees and would be able to walk." (T.49-50). Other than Petitioner's speculative testimony, there is no evidence of any job search or job log in the record. It is unknown what jobs Petitioner searched for, applied to, when, or where. Petitioner also did not meet his burden under the second available option. Petitioner relies on the vocational counselor's opinion to establish that "because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market." However, Petitioner never even met with Ms. Helma. In fact, Ms. Helma reached her conclusion that Petitioner was totally disabled based on one telephone interview. She herself acknowledged in her report that since she did not personally meet Petitioner, she could not assess his personal presentation or whether he manifested any pain behaviors. (PX13).

Ms. Helma's opinion is not only unpersuasive, but confusing. On the one hand, Ms. Helma stated that Petitioner has no transferable skills, and that sedentary, unskilled occupations comprise of 1% of the labor market. Then on the other hand she notes Petitioner's extensive history of skilled work, not all of which encompass heavy duty work. Taking Petitioner's experience and skills into account, and the fact that he earned $13.00 per hour with Respondent, it cannot be said that Petitioner is unable to secure permanent employment. In other words, Petitioner insufficiently established that he is permanently and totally disabled under an "odd-lot" category.

With that said, our Appellate Court has stated that the Commission is obligated to consider a wage differential award "when there is evidence in the record that could support a wage differential award . . . and when nothing in the record suggests that the claimant elected to waive his right to recover such an award." *Lenhart v. Ill. Workers' Comp. Comm'n*, 2015 IL App (3d) 130743WC ¶52. Here, by the evidence in the record and by his brief, Petitioner failed to present evidence regarding his entitlement to a wage differential award, and as such has implicitly waived

his right to such an award. *Id.*, citing *Gallianetti v. Indus. Comm'n*, 315 Ill. App. 3d 721, 729 (2000). The evidence as it now stands is insufficient to determine whether suitable employment, in which Petitioner is both able and qualified to perform, is available; and, if such employment is available, whether the employment would result in an impairment of earnings; and, if such impairment exists, there is insufficient evidence to properly calculate the wage differential award. *Crittenden v. Ill. Workers' Comp. Comm'n*, 2017 IL App (1st) 160002WC.

In consideration of the foregoing, the Commission finds that Petitioner failed to prove that he is permanently and totally disabled under an "odd-lot" category, and has failed to prove that he is entitled to a wage differential award under Section 8(d)(1) of the Act. However, Petitioner did establish that as a result of the April 19, 2011 accident, he suffered complex lateral meniscal tears to both knees, and necessitated injections, physical therapy, and arthroscopic surgery to his right knee. (T.23; PX1; PX2). Petitioner also suffered partial-thickness tears involving the rotator cuff tendon with a focal full thickness tear, and partial tear and/or tendinopathy involving the long head of the biceps tendon. (PX4). With these injuries, Dr. Burton did not believe Petitioner was able to return to his previous level of activity and previous job with Respondent, and neither did Ms. Helma, Petitioner's vocational counselor. (PX1; PX13).

Thus, while the Commission vacates Petitioner's permanent and total disability benefits pursuant to Section 8(f) of the Act, the Commission finds that an award of 50% loss of use of the person as whole, under Section 8(d)2 of the Act, proper given the evidence in its entirety.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed April 17, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the permanent and total disability award pursuant to Section 8(f) of the Act is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $312.00 per week for a period of 250 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused 50% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $346.67 per week for a period of 55 weeks, from April 19, 2011 through January 3, 2012 and from March 30, 2012 through August 1, 2012, 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 pay to Petitioner the sum of $2,200.50 for medical expenses under Sections 8(a) & 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,

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including credit under Section 8(j) of the Act, and shall hold Petitioner harmless for same.

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 the Circuit Court.

DATED: JUN 15 2018
MJB/pm
O: 06-04-18
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

FINK, DAVID
Employee/Petitioner

Case# **12WC003215**

A C McCARTNEY FARM EQUIPMENT
Employer/Respondent

18IWCC0388

On 4/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

5001 GAIDO & FINTZEN
MICHAEL T CHALCRAFT II
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

18IWCC0388

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
CORRECTED ARBITRATION DECISION

David Fink
Employee/Petitioner

v.

AC McCartney Farm Equipment
Employer/Respondent

12WC 03215

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

DISPUTED ISSUES

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

FINDINGS

On **April 19, 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 **$27,040**; the average weekly wage was **$520.00**.

On the date of accident, Petitioner was **51** years of age, **married** with **0** children under 18.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

ORDER

Credits
Respondent shall be given a credit of $13,777.23 for TTD, $0 for TPD and $0 form maintenance benefits for a total credit of $13,777.23

Respondent shall be given credit of $25,961.03 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Medical benefits
Respondent shall pay reasonable and necessary medical services of $ 2,200.50, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

TEMPORARY TOTAL DISABILITY
RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF $346.67/WEEK FOR 55 WEEKS COMMENCING 4/19/2011THROUGH JANUARY 3, 2012 AND FROM 3/30/2012 THROUGH AUGUST 1, 2012 ..

Permanent Total Disability:
Respondent shall pay Petitioner permanent and total disability benefits of $466.13/week for life , commencing August 2, 2012 as provided is Section 8(f) of the Act.

Commencing on the second July 15 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.

D. Dhas McCarty 4/10/17

Signature of Arbitrator Date

APR 17 2017

STATE OF ILLINOIS)
) SS
COUNTY OF ADAMS)

18IWCC0388

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID A. FINK,	)	
	)	
Petitioner,	)	
	)	
v	)	IWCC: 12WC 03215
	)	
AC McCARTNEY FARM EQUIPMENT,	)	
	)	
Respondent.	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

Testimony of Petitioner:

Petitioner has filed an Applications for Adjustment of Claim due to an injury on April 19, 2011. Petitioner is currently 57 years of age. (T13) He dropped out of high school after his freshman year. (T13) He has not had any special training but has worked in the agricultural business as a mechanic in factories, shop foreman and setup of agricultural machinery. (T13-14)

Petitioner had worked at the same facility since about the year 2000 and stayed there when the current owner purchased the business in 2008. (T14-15) Physically, his job involves setting up heavy machine parts, building the agricultural machinery as it comes in, unloading trucks, delivering machinery and doing mechanical work such as repairing equipment. (T15) The most he would lift is 200 pounds. Some parts weigh over 250 pounds. (T15) If he couldn't lift it and carry it, the forklift would help move it. (T15-16) He usually lifts weights from anywhere between 25 and 150 pounds. (T16)

Petitioner stated that he had no major problem with his right knee but he did have some medical care from Dr. Gene Cross in Quincy which occurred before his accident of April 19, 2011. (T39-40) He had an injection in his right knee by Dr. Cross. When asked if the injection was done about three years prior to April 19, 2011, Petitioner said he wasn't sure but it was quite a while before the injury of April 19, 2011. (T40)

On April 19th he was in charge of unloading large machinery from a semi. (T18) A truck came with a load of machinery and he went to unload it with a large forklift. (T18) He unloaded the truck, parked the fork truck in storage and then hopped down off the fork truck. (T18) He twisted his right knee. (T18) There were some large rocks and he thinks he may have stepped on one, twisting knee as he landed. He managed to walk to the shop with a lot of sharp pain and discomfort. (T20)

The platform where his feet set on that machine was approximately five feet off the ground. (T19) The seat was probably six feet from the ground. (T19) When you step off the fork lift, there is a small step, probably two and a half feet from the platform to the ground. (T19)

The area where they park the forklift was full of junk that he cleaned out and removed for the mechanics to be able to work. (T19) The last day he worked was April 19, 2011. Petitioner had no problem walking with his right knee prior to April, 2011. (T27)

On July 4, 2011, the Petitioner was going to take his grandsons to the fireworks. (T25) Petitioner lives in a split foyer house, he had seven steps to the door. (T25-26) There was nothing on the stairway that could cause him to fall. (T26) As he started down the top flight of the stairs, his right knee gave out and he fell down the stairs. (T26) He pulled his right shoulder, hurt his left knee in a bad way. as well as injuring his ankle. (T26) He just landed really wrong in a (T26, 27) The next morning (July 5) he called Workers' Comp and asked if he could go to the emergency room. His request was denied. (T26)

He said that a couple of times after his accident on April 19 his right knee had a sharp pain and gave out. (T45) He had probably fallen two or three times prior to falling on July 4. (T26)

Prior to the fall, he would just get a shot of a sharp pain in his right knee and the knee would just buckle, causing him to fall to the ground. (T25) In most instances, he was walking on a flat surface. (T27)

His left knee was not bothering him prior to July 4, 2011, thought it may have bothered him in the past from crawling on concrete. (T28, 36)

With regard to his right shoulder prior to July 4, 2011, he had occasional pain because of the 2010 injury. (T28) He would go to the chiropractor and get adjusted and kind of lived with it but had some discomfort in the shoulder for a long time. (T28)

While under the care of Dr. Derhake, he remained off work until somewhere around January 2012. (T23-24) He did go back to work for about three months. (T24) They had a driver who lost his license. (T24) Petitioner would drive the other employee to pick up machinery and when he wasn't driving, he would fill out paperwork. (T24) The co-employee who lost his license regained it three months later. (T24) The time period was approximately from January through March of 2012.

On February 2, 2012, Petitioner was examined by Dr. Richard Lehman at the Respondent's request. Petitioner believes he was on temporary duty when seen by Dr. Lehman and it was after seeing Dr. Lehman that his disability benefits were stopped. (T46, 34) They also stopped paying his medical bills. (T34)

After seeing Dr. Lehman, the employer offered Petitioner full duty work. (T46-47) Mr. McCartney is the owner of the company and manager. (T25) Mr. McCartney called Petitioner into the office and told him that he wanted Petitioner to go back to full time work on the combine. (T25) Petitioner told the employer that he could not do his regular job as he could hardly walk and was unable to climb. He further advised his employer he was under the care of a doctor for his condition. (T 25; 47)

Thereafter, the Petitioner was not offered light duty. (T24-25) After he left Respondent, he did look for a job. (T47) He told Respondent that he was going to file for unemployment and then Social Security. (T48)

He filed for unemployment, did job searches and later went on Social Security Disability. (T48) He drew unemployment for 20 weeks or something like that but he was never employed since he left Respondent. (T48)

Unemployment required him to do two job searches a week. (T49) Petitioner found two employers that would have probably hired him if he didn't have a bad knee and was able to walk. (T49-50) No one offered him a job. (T50) His employer has not offered him any job since he left. (T32) He still has restrictions of a 15 pound weight restriction and no standing for more than two hours which are the ones he can recall at this time. (T32)

Medical:

Petitioner initially sought care at the Memorial Hospital Emergency Room on April 19, 2011. His history was that he had twisted his right knee getting off a forklift that day. He complained of lateral knee and leg pain. His examination showed tenderness and effusion. The diagnosis was right knee pain; rule out internal derangement. His knee was immobilized and he was told to see an orthopedist in two to three days. (PX 14)

Petitioner was next treated by Matthew Burns, a nurse practitioner in the orthopedic department of the Quincy Medical Group, on April 25, 2011. He obtained a history that the Petitioner had kind of jumped down off a forklift and as he did so he twisted his right knee causing shooting pain and having difficulty bearing weight. Examination showed no obvious sign of a breakdown or infection. There was mild palpable tenderness appreciated over the right lateral joint and over the LCL. The knee was stable to varus and valgus artery as it decreased discomfort in a lateral aspect of the varus stress. He was diagnosed with a right lateral collateral ligament sprain. He was to be seen in physical therapy and return in three weeks. He was also given a note on April 26, 2011 with restrictions for the requirement of wearing a hinged knee brace, no work requiring repetitive bending with the right knee, he should be sitting 50% of the time, he should have no climbing of stairs or ladders, no repetitive shoveling or lifting, pushing or pulling over 10 pounds, no kneeling or squatting. (PX 2)

Petitioner returned to Mr. Burns May 16 noting that he was somewhat better. Range of motion had improved from zero extension to 120 degrees flexion. An MRI was recommended. On that date, he was given restrictions of no climbing of stairs or ladders, no work requiring repetitive bending of the right knee and he needs to wear a hinged knee brace, no repetitive shoveling, lifting, pulling or pushing over 10 pounds and no kneeling or squatting.

On May 19th at Memorial Medical Center (PX4), Petitioner underwent an MRI of the right knee without contrast. There was a complex degenerative tear involving the entire lateral meniscus with both horizontal and radial components. There was associated anterior extrusion of the interior horn of the lateral meniscus. He had mild to moderate tri-compartmental osteoarthritis worse in the lateral compartment. He had associated knee effusion and intra-articular body with impact excruciating and collateral ligaments.

Petitioner was seen then by Dr. Adam Derhake, an orthopedist with Qunicy Medical Group on May 31. Dr. Derhake reviewed Petitioner's x-rays, examined his knee and reviewed the MRI. His assessment was that of a relatively new onset of lateral sided right knee pain with some underlying degenerative changes. Findings are consistent with a lateral meniscus tear. The doctor felt that Petitioner's symptoms were likely due to the tear of the meniscus itself. Dr. Derhake gave Petitioner a note that he could return to work with no climbing of stairs or ladders, no repetitive shoveling, no lifting over 10 pounds, no pushing or pulling over 10 pounds or crepitus with range of motion. (PX 2)

Petitioner returned to Dr. Derhake again on June 8, 2011. The doctor reviewed the MRI with the Petitioner and recommended surgery. The Petitioner was again given the same restrictions as previously noted.

On June 20th, Petitioner saw Kelly Rife, CNP at Hancock County Health for a pre-op examination. She noted he had a grinding pain in the right knee. On July 4, 2011, the Petitioner fell at home as his testimony noted above indicated. Two days later, he was again seen by Nurse Rife. His history was that he had fallen down some deck steps at home on July 4 because his right knee "gave out." He complained of pain in the left knee and right shoulder. Nurse Rife's examination showed tenderness over the gleno-humoral joint and acromioclavicular joint pain with resisted abduction, pain with resisted internal rotation, pain with resisted external rotation. Range of motion of the right shoulder was decreased in abduction, there was pain with adduction and internal rotation. There was weakness. The left lower extremity showed no effusion but there was positive patellar grind, range of motion of the right knee is decreased in flexion and there is pain with flexion. The right ankle has a normal examination but with pain with range of motion and stability. She diagnosed the Petitioner with a sprained right ankle, left knee and right rotator cuff. (PX 20)

The Petitioner on July 7, 2011, underwent surgery with a pre-operative diagnosis of complex right knee lateral meniscus tear, small horizontal tear of meniscus horn, and medial meniscus. The post-operative diagnosis was: 1) complex right knee lateral meniscal tears; 2) small horizontal tear of the posterior horn, medial meniscus; 3) grade iii and grade iv chondromalacia changes in the patellar femoral joint; and 4) focal area of grade iii and grade iv chondromalacia changes in the medial femoral condyle. The procedure performed was that of a

1) right knee arthroscopy with partial medial and lateral meniscectomy; and 2) right knee arthroscopy with chondroplasty of medial femoral condyle as well as the patellofemoral joint.

Petitioner was seen again by Dr. Derhake on July 8th post-surgically. He concluded that most of Petitioner's post-operative pain was in the lateral joint line where he was found to have a very large complex tear throughout the lateral meniscus. He prescribed crutches and ordered physical therapy. That same day, he was given a note that he could not return to work.

Petitioner saw Dr. Derhake on July 21, 2011 with regard to his post-status right knee arthroscopy with partial medial and lateral meniscectomy and severe degenerative changes in the medial and lateral compartments. He has been participating on occupational therapy but has significant symptoms of pain and swelling. He has occasionally experienced given way of the right knee. He noted that the giving way led to the injury of July 4 when his right knee gave way causing the injury to this left knee as well as his shoulder.

Dr. Derhake saw the Petitioner again on August 12, 2011. He was one month post-op. He is improving slowly. He noted the July 4th giving way of his right knee. The symptoms of the right knee remain. There is full range of motion with tenderness to palpation diffusely throughout both the medial and lateral joint lines. There was a significant 2+ patellofemoral crepitus with range of motion. Significant quadriceps contraction weakness as compared to contra-lateral lift in the lower extremity. All signs are negative. The doctor felt the instability and feelings of giving way were secondary to continued quadriceps contraction weakness in the right lower extremity compared to the left. He recommended the right knee intra-articular corticosteroid injection. The Petitioner declined the shot because he thought would only mask the symptoms. Physical therapy was recommended. Dr. Derhake gave him a slip not to return to work.

On August 26, 2011, Petitioner was seen at Memorial Hospital for x-rays of the left knee. The impression was that of negative acute fracture and subluxation, minimal degenerative change and possible loose body noted in anterior to distal femur. (PX4.14.15)

Dr. Derhake saw the Petitioner on September 9, 2011. He returned post-arthroscopy and noted severe chondromalacia changes were found in all three compartments. He continued to complain of contralateral knee pain. He is having similar complaints in both knees. He does have some grinding and recurring swelling of the knee and felt he was unable to go back to

work secondary to his symptoms. The doctor's assessment plan, he noted two months status post right knee arthroscopy with partial medial and lateral meniscectomy with significant chondromalacia changes and now with continued bilateral knee pain. The pain is currently explained by the significant amount of degenerative changes found in the knee. The doctor explained to him that feeling worse is a result of the arthroscopic surgery and that he developed significant quadricep weakness and that weakness can contribute to increased stress across the knee joint and make the arthritic symptom more pronounced. The Petitioner told the doctor that he was going for another opinion to Dr. Burton, an orthopedist. Dr. Derhake wrote that this was an excellent idea. (PX 2)

On September 14, 2011, Petitioner saw Dr. Curtis Burton of Midwest Orthopedic Specialists. (PX1) The Petitioner gave him a history of his accident hopping off the fork truck as well as his July 4 fall down the steps. Dr. Burton noted that the Petitioner worked for the Respondent for 14 years with a job involving a lot of crawling and squatting and time on his knee. It was noted that he was very sensitized around the front of his knee and states he really would not be able to do anything like that at this point. His examination showed right knee effusion and full extension and flexion. He does limp when he walks. He has a large callous across the front of the knee from chronic kneeling. He has equivocal MacMurray on the right with some discomfort on the left. He has crepitus but not much pain with loading the patellar through range of motion on either side. X-rays were taken. The impression was that of degenerative change with a superimposed twisting injury and status post arthroscopy of the right knee. Dr. Burton believed that the Petitioner had some degenerative changes on the super imposed injury and was a candidate for Viscosupplementation. He stated it would be tough for the Petitioner to return to work because of the kneeling and sensitivity he had in the front of his knee but thought he could accomplish that as he appears now. Dr. Burton noted that the Petitioner had a preexisting condition but thought that the connection between his right knee injury and the work claim was fairly clear. (PX 1)

Petitioner again saw Dr. Burton on October 12, 2011. Apparently the treatment wasn't authorized but he did get his first Supartz injection in the right knee. An MRI was being scheduled. Dr. Burton gave Petitioner a note indicating he was unable to work. On that same date, Dr. Burton completed a form based upon Petitioner having his first disability of July 5,

2011 and was last treated on October 12, 2011 On that date, Dr. Burton gave Petitioner a slip noting that he was unable to work.

On November 10, 2011, Respondent prepared an initial disability claim form regarding the first date of disability being July 5, 2011.

On November 14, 2011, Petitioner underwent an MRI of the left knee at Memorial Hospital under the care of Dr. George March. The impression from the MRI of the left knee was that the Petitioner had knee effusion with presumed reactive type synovitis and particulate debris; moderate osteoarthritis; complex lateral meniscus tears; and focal deformity increased T2 signal distal popliteal tendon likely representing an old post traumatic change.

On November 16, 2011, Dr. Burton administered the second Supartz injection of the right knee. He reviewed the MRI of the left, and felt the Petitioner was a candidate for the LEVAGE arthroscopic on the knee and an injection as well. The doctor prepared a note indicating the Petitioner was still unable to work.

On December 12, 2011, Petitioner saw Dr. Burton in follow-up after three sessions of therapy. The therapist was of the opinion that he lost some muscle in the right side since he has been out of therapy. His pain is mainly up on the right. He has pain over the tibia tubercle and anteriorly over the knee. He was not substantially better in terms of pain and walking from when he was seen a month ago after his third Supartz injection. He does have essentially full extension and flexion back to 125 degrees. He stated he previously spent hours of time during the day on his knees and had no problem with squatting like a catcher but he really can't do it now. In the MRI, they noted he has a reactive synovitis, moderate osteoarthritis and lateral meniscal tear.

At that visit, Dr. Burton gave the Petitioner a work status note indicating that he was able to return to limited work, light duty with no lifting more than 10 pounds and one hour continuous standing, three hours maximum in the daytime.

Petitioner returned to Dr. Burton on January 23, 2012. He noted that Petitioner could work eight hours a day but must follow a standing limit of three hours, one hour continuous, each day. He could lift up to 10 pounds and work light duty.

On February 2, 2012, Petitioner was examined by Dr. Richard Lehman, an orthopedist, at the Respondent's request.. He reviewed records from 2000 up to 2011. He concluded that the Petitioner had bilateral preexisting degenerative arthritis in his knee and symptoms were not in

any way related to work. He reviewed x-ray's taken June 29, 2009 which he said showed moderate osteoarthritis in the lateral femoral compartment on the right knee with mild changes in the medial compartment, as well as a possible loose osteochondral body on the left knee. The Arbitrator notes the x-ray's were not placed into evidence. He felt that the arthroscopic findings were all in concert with preexisting degenerative arthritis which is a long term condition and not related to work. He felt Petitioner could work without restriction. He did not feel there was any disability related to work. He said the Petitioner does need treatment and a work up of the left knee and potentially a total knee replacement of the right, as well as an MRI on the shoulder. He stated that Petitioner is at maximum medical improvement for his work injuries. He felt Petitioner could work without restriction. (RX 1)

On April 4, 2012, Dr. Burton again saw the Petitioner. The Petitioner said that he had originally injured the shoulder at work lifting a transmission but when he grabbed the railing on July 4, his shoulder was jerked and he had pain ever since. Dr. Burton also noted ongoing bilateral knee pain due to osteoarthritis.

On April 13, 2012, Petitioner underwent an MRI of the right shoulder because of complaints of pain, weakness and decreased range of motion. The impression was that of: 1) osteoarthritis of the right shoulder; 2) at least a partial thickness tear involving the rotator cuff tendon with focal full thickness tear; and 3) partial tear and/or tendinopathy involving the long head of the bicep tendon. The bicep tendon is subluxed anteriorly out of the bicipital groove.

Dr. Burton again saw the Petitioner on April 18, 2012 with regard to primarily his shoulder. He told the doctor that he had injured his shoulder lifting a transmission some years ago which sounded as though he had minimal intervention and no imaging. When his knee buckled and he ended up falling down seven stairs at home, grabbing the railing, jerking his arm in an abduction fashion, it has given him problems since but he focused on the knee. The arm hurts as he pulls on things or stretches his bicep. He has pain reaching over head. He has been babying the shoulder and he has some pain at night as well. He is currently laid off at this time.

Physical examination noted minimal neck tenderness, no significant crepitation of the shoulder motion. There was some crepitation with range up and abducted. He is tender to testing biceps. His grip strength is weak. The MRI showed a probable full thickness tear of the anterior part of his supraspinatus tendon, a partial tear of the long end of the biceps tendon and it

seemed subluxed. X-rays did not show any arthritis in the shoulder. Dr. Burton suggested arthroscopic examination of the shoulder, fixation of the biceps tendon and possible repair of the rotator cuff and evaluation of articular surfaces. Petitioner was given a restriction indicating that he is not capable of returning to work.

On June 1, 2012, Dr. Burton prepared a narrative report. (PX 5) In that report, he diagnosed Petitioner as having a right knee sprain superimposed on degenerative arthritis and a shoulder strain after the give way in the episode. He opined that it was unlikely that he will be able to return to unlimited kneeling and squatting and standing because of both knees. His shoulder function had not returned to that of the pre-fall condition. Dr. Burton stated the Petitioner's prognosis for recovery is guarded. With regard to causation, Dr. Burton said that it appeared that his work-related injury exacerbated his preexisting arthritis of the right knee. The doctor also stated his current restrictions are related to the arthritis of his knees. His restrictions are limited ability to stand, limited flexibility to both knees. He also has some limitation of function in the shoulder. Further evaluation of the shoulder would be recommended. Dr. Burton stated the Petitioner's prognosis for recovery is guarded.

On August 1, 2012, Dr. Burton noted that the Petitioner had no significant improvement in his right shoulder. He has restricted range of motion, about 60 degrees at forward flexion, and it is painful with impingement testing and painful with abduction. He uses both his arms to get himself out of the chair because of his knee condition.

He has not had any recent treatment for either of his knees nor his shoulder. (T30-31) He is currently on Social Security Disability based upon a decision that he became disabled on April 19, 2011. (PX 10)

At arbitration, the Petitioner said his right knee is not any better and in fact is quite a bit worse. (T35) He has a lot of pain in the knee, stiffness, locking and a popping noise when he walks. (T35) He did not have those problems prior to the accident.

With regard to his left knee, he has a lot of pain, discomfort, sharp pain, locking and stiffness. (T36) He wasn't sure if he had injured his knee before but he might have done something while crawling on cement under a machine. (T36)

His right shoulder has a lot of pain and stiffness and his motion is limited. (T36) He lost a lot of strength in his right arm and believes he has a rotator cuff tear and a torn bicep muscle per Dr. Burton. (T36)

Petitioner tried to get his expenses covered by Medicare but they would not do so until there was an Agreement from Worker's Comp. (T37)

Worker's Comp paid the surgery for his right knee. They did not cover his shoulder so his COBRA insurance covered his care. Petitioner paid the deductible on his insurance of $1,000. (T38) Petitioner had no surgery on his right shoulder. (T38)

Social Security and vocational assessment:

The Petitioner was approved for social security disability benefits with an onset date of April 19, 2011. Based upon the medical records and an examination performed for the SSA, the determination was that the Petitioner was limited to sedentary work. Based upon Administrative Rule 201.10, which considered his above limitations, his age, work experience and education, he was found to meet the definition of disability. (PX 10)

Petitioner was interviewed by Lisa Helma, CRC, of Vocomotive on October 16, 2014 at his attorney's request. The evaluation report reflects her opinions as follows:

1. Based upon the medical opinion of Dr. Burton, Mr. Fink has lost access to his usual and customary line of occupation as a set-up mechanic.
2. It is her opinion, based upon Dr. Burton's findings, given his age, level of education, lack of computer skills, previous work experiences, physical capacities and lack of transferable skills, Petitioner has lost access to a stable labor market. She concluded that his disability is total.

In support of Arbitrator's Decision relating to C, Accident, the Arbitrator finds the following facts:

Petitioner testified without rebuttal that he injured his right knee when he hopped off his fork truck at work on April 19, 2011. He said that the truck platform was five feet above ground and that the step between the platform and the ground was two and a half feet above ground. He said there were rocks on the ground and he may have landed on one. He said he noticed

immediate pain. He said that he notified his employer, and the employer's first report of injury corroborates this testimony. (PX 22)

He went to the emergency room that day and gave a consistent history of accident. His examination findings were consistent with an acute injury to the right knee. He was found to have effusion and tenderness in the knee. He was given an immobilizer and told to elevate the leg and use ice. He was prescribed Motrin and Norco and told to see an orthopedist within two to three days. (PX 14) His follow up care from the orthopedic department at the Quincy medical began shortly thereafter. He remained under care through July 7, 2011 when surgery was performed. His symptoms throughout the period of time were consistent with an injury to the right leg.

No evidence was offered to rebut the Petitioner's claim of accident. Respondent only argues that the Petitioner was not credible with his testimony at arbitration, and so his claim of an accident should be rejected. The Arbitrator has read the transcript and finds the Petitioner credible. While it is true that he did indicate on direct exam that he was not having any trouble walking prior to his accident, he did acknowledge that he had some treatment to the right knee in 2009. In fact, he even offered into evidence records of said treatment. (PX 24) Those records showed that he saw his family medical group in June 2009 with right knee pain and that it was recommended that he see an orthopedist. He testified that he saw an orthopedist and received one injection to the knee. No records were offered to show any ongoing knee treatment between mid 2009 and April 19, 2011. Moreover, when asked on cross examination whether his right knee was giving him problems prior to the accident, he said that he was having no problems like he was having now. (TR 39)

The Arbitrator finds the Petitioner's consistent symptoms and findings after his accident as reported to all of his medical providers more than outweighs any issues which might have arisen from his testimony. He had some knee pain in 2009. He continued to perform his regular job which was heavy in nature until April 19, 2011. Since that time he has had ongoing right knee symptoms and findings which are consistent with the injuries found in surgery.

The Arbitrator finds that the Petitioner did sustain an accident arising out of and in the course of his employment on April 19, 2011.

In support of Arbitrator's Decision relating to F, causation, the Arbitrator finds the following facts:

It is undisputed that Petitioner had difficulties with his knees. As he described from his work activity, he crawled a lot on hard surfaces over the years that he worked for the Respondent and its predecessor. He agreed that he had some problems with his knee prior to the accident. However, he had not seen any doctor nor had he received any medical care in the recent past dealing with his right knee.

The chain of events before and after the accident referred to in the preceding findings concerning accident support causation. The Petitioner had no treatment and performed a heavy physical job from mid 2009 until April 19, 2011. From that date forward, he received medical care with findings consistent with a right lateral meniscus injury culminating in surgery on July 7, 2011.

Dr. Burton in his report opined that the accident exacerbated the preexisting arthritis in the right knee. (PX 5)

Dr. Derhake's treatment notes also support causation with respect to the right knee. His nurse practitioner's first impression was that of an injury to the lateral aspect of the knee during his examination on April 25, 2011. On May 31 Dr. Derhake noted lateral joint pain on exam. On the day following surgery, Dr. Derhake authored a progress note which supports causation. He said that while the Petitioner did have significant findings in both the medial and patellofemoral compartments, most of his preoperative pain was in the lateral joint line where he was found to have a very large complex tear throughout the lateral meniscus. (PX 2)

Respondent's examining physician, Dr. Lehman opined that all of the Petitioner's injuries were the result of extensive preexisting arthritis. The Arbitrator does not find his opinions persuasive. The doctor notes the preexisting condition in the right knee but ignores the post accident findings on the MRI and operative report showing the complex tear of the lateral meniscus. More importantly, his report does not contain any comment on the Petitioner's ability to work full duty at a heavy demanding job prior to the accident without ongoing medical care and his inability to perform said job while requiring regular medical care with consistent findings after the accident. Whether the pathology seen by Dr. Derhake in surgery was new or old is

insignificant. The evidence supports causation with respect to the right knee, either as a new injury to the lateral meniscus or an aggravation bringing about the need for care.

There are no medical opinions directly dealing with causation between the accident and the Petitioner's fall on July 4, wherein he injured his left knee and right shoulder. The Arbitrator finds that the evidence again supports causation. First of all, we know that the Petitioner's right knee was injured prior to his July 4 fall as he was scheduled for surgery three days later. He testified that since his accident, his knee would give way causing him to fall. Dr. Derhake commented in his note of August 12, 2011 that the giving way and feelings of pain and instability are secondary to quadriceps contraction weakness in the knee. (PX 2) It is also clear from the treatment notes beginning with that of Kelly Rife on July 6 that the Petitioner did injure his left knee and shoulder when he fell. He has had ongoing treatment with consistent findings since that time and Dr. Burton and Dr. Lehman think he may need more treatment including surgery on the right shoulder.

Importantly, this incident of July 4 was in no way an intervening event breaking the causal chain concerning the right knee. The medical records and the Petitioner establish that the fall did not even injure the right knee. He went ahead with his surgery three days later.

In summary, the evidence supports causation between the accident of April 19 and the Petitioner's present conditions of ill being. He testified to his limitations and he has continued to receive care form his family physicians with no appreciable gaps in said treatment. (PX 11) The Arbitrator finds that the Petitioner current conditions of ill being concerning both knees and his right shoulder to be causally relate to his accident.

In support of Arbitrator's Decision relating to J, medical, the Arbitrator finds the following facts:

Respondent initially paid the Petitioner's medical bills related to his right knee injury up until the time of their examination by Dr. Lehman on February 2, 2012.

Given the findings with respect to accident causal relationship, the Arbitrator finds Respondent liable for the following medical bills:

Blessing Hospial:	$2.070.75
Midwest Orthopedics	$ 105.00

IHFS $ 24.75

Respondent shall pay reasonable and necessary $ 2200.50 subject to the medical fee schedule.

In reviewing the bills incurred subsequent to the opinion of Dr. Lehman and the Respondent's chose to cease payment of medical billings, the Respondent shall be responsible for any and all medical bills paid by Petitioner's group health companies, particular MCIM and Personal Insurance Co. and Coventry Health and Life Insurance Co.

In support of Arbitrator's Decision relating to K, temporary total disability, the Arbitrator finds the following facts:

Respondent has paid a portion of the Total Temporary Disability benefits to which the Petitioner is entitled.

Both Dr. Derhake and Dr. Burton prepared a narrative indicating there was a causal connection between the work related injury which exacerbated preexisting conditions in his knee and created new ones. The current restrictions include limited standing, limited flexion to be accommodated for both knees and they represent permanent restrictions.

Petitioner's last medical visit, specifically for his injury, was with Dr. Burton on August 1, 2012.

The Arbitrator therefore finds Petitioner is entitled to total temporary disability benefits with a period of April 19, 2011 through January 3, 2012 and from March 30, 2012 through August 1, 2012. By the last date, Petitioner had reached maximum medical improvement as no corrective treatment was had.

In support of Arbitrator's Decision relating to L, nature and extent, the Arbitrator finds the following facts:

The Petitioner is seeking an award of permanent and total disability benefits under Section 8 (f) of the Act. He claims he fits the "odd lot" category defined by numerous decisions of both the Supreme and Appellate Courts. In the case of Professional Transportation, Inc. v. The Illinois Workers Compensation, the Appellate Court laid out the test for proving an "odd lot"

perm total. They said it could be established in one of three ways. First, it could be shown by a preponderance of the medical evidence. In the instant case, the Petitioner has not shown by the medical evidence to be totally disabled. His doctors have opined that he could work with restrictions. Secondly, it could by shown by a diligent, but unsuccessful job search. No job search was performed by the Petitioner. Finally, a petitioner could demonstrate that, because of his age, training, education, experience and condition that there are no available jobs for a person in his circumstance. See 966 N.E. 2d 40, 46 (2012) The Arbitrator believes that the Petitioner has established entitlement to the award requested by the third test.

First of all, when he reached a point of maximum medical improvement on August 1, 2012, the Petitioner was 53 years old. The Social Security Administration characterized him to be closely approaching advanced age under their administrative rules. (PX 10) He has a limited education, with his last grade completed being the eighth. He did not obtain a GED certificate. He went to work after eighth grade on a farm, which begins his work experiences. All of his subsequent work was physical in nature. He worked in a lumbar yard, in several factories operating machines and as a mechanic working on tractors and combines. All of the work was strenuous and required more by way of function than his injuries will allow. By all accounts, he has a torn rotator cuff in the right shoulder and two knees which will need to be replaced. Both the vocational expert and the SSA determined that he was unable to perform any of his past relevant work. Ms. Helma, the vocational expert, further concluded that he had no acquired work skills which would transfer to any sedentary type jobs consistent with his physical limitations. She further opined that sedentary unskilled jobs account for only 1 % of occupations in the U.S. labor market. She concluded that he was unemployable. (PX 13)

The Arbitrator feels that with the above evidence, the Petitioner has met his burden of showing the unavailability of employment. As the Court in Professional Transportation points out, the burden then would shift to the Respondent to show that suitable work which is regular and continuous is available. (Id at 47)

The Respondent may have been able to meet its burden had they continued to employ the Petitioner in a driving job as they did on a temporary basis in early 2012. However, they elected to rely on Dr. Lehman's opinions and gave the Petitioner the take it or leave it option of returning to regular duty against the restrictions established by Dr. Burton. When the petitioner

declined the offer he was laid off. That occurred in early 2012. At no time did the Respondent do a vocational assessment or offer any vocational help. They instead relied upon a causation defense in the case.

The evidence shows that the Respondent failed to meet its above stated burden. As such, the Petitioner is awarded permanent and total disability benefits pursuant to Section 8 (f) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Isaac Dixon,
Petitioner,

vs.

No. 09 WC 25643

Chicago Transit Authority,
Respondent.

18IWCC0389

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 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.

Facts:

Petitioner, a bus driver, testified that on December 15, 2008 he slipped on ice after exiting his bus, striking his left knee and losing consciousness. He received emergency room care that day for pain in his left side and left knee. Two days later, he received care at Concentra for knee and back pain. Petitioner ultimately underwent arthroscopic left knee surgery with Dr. Brooker for a torn medial meniscus, on March 24, 2009. Petitioner testified that surgery didn't help, though records showed his condition did improve. Dr. Brooker referred Petitioner to pain management physician, Dr. Gandhi for ongoing back and left leg pain.

Following unsuccessful conservative back treatment, Petitioner underwent an L3-L4 microdiscectomy with Dr. Lim on February 17, 2011. Petitioner's symptoms increased a few months after that surgery and after an undescribed injury. Dr. Lim recommended Petitioner undergo a lumbar fusion, which Petitioner ultimately decided to forgo on the advice of his primary doctor. Instead, Petitioner treated with pain management physician, Dr. Harsoor, from February 2014 until April 2015.

Petitioner has other unrelated health issues which include borderline diabetes, hypertension and right knee arthritis. He was diagnosed with and still treating for prostate cancer. Petitioner's doctors kept him completely off work until January 11, 2013, at which time Dr. Lim released him to return to light duty work. Petitioner testified he believed he could work, but admitted he has not looked for any work since his accident.

Carl Triebold, Petitioner's rehabilitation counselor, testified he interviewed Petitioner on June 27, 2016. Petitioner has a high school diploma and some college credits, but his only occupation in the past 15 years was that of a city bus driver. Mr. Triebold believed Petitioner had no transferrable skills outside of driving, a medium physical demand level job. He opined that based on Dr. Goldberg's "restriction," Petitioner was unable to drive a bus or performed any work which involved driving, though he could find work paying between $8.25 and $12.00 per hour. Mr. Triebold admitted he had not considered Dr. Goldberg's accompanying opinion: that he found no objective basis for restricting Petitioner from driving. Mr. Triebold testified that if he based his opinion on Dr. Lim's and Dr. Brooker's restrictions, there would be no stable labor market for Petitioner. Mr. Triebold admitted he never conducted a labor market survey or reviewed a formal functional capacity evaluation.

Dr. Lim testified via deposition that he saw Petitioner on November 24, 2009 for complaints of left-sided knee pain and low back pain following a work injury. Upon examination, Dr. Lim found Petitioner had symptom magnification and two out of five positive Waddell's signs. Though Dr. Lim found Petitioner's pain to be out of proportion, he took Petitioner off work and ordered an MRI which showed a herniation at L3-L4. Despite conservative treatment and epidural steroid injections, Petitioner' condition worsened and Dr. Lim performed an L3-4 microdiscectomy. Thereafter, Petitioner leg pain and overall condition improved, but then began to deteriorate, after Petitioner reported an intervening injury. Dr. Lim kept Petitioner off work through 2012, and last saw Petitioner on January 11, 2013. Dr. Lim opined: Petitioner's back condition was causally related to his work accident; his treatment and surgery were reasonable and necessary, and Petitioner was unable to work between November 24, 2009 and October 2012. Dr. Lim had no opinion regarding Petitioner's current condition or whether he could now work full duty without restrictions.

Dr. Brooker testified via deposition that he first saw Petitioner on January 19, 2009 with complaints of work-related knee and back pain radiating down his left lower extremity. His MRI's showed mild lumbar nerve impingement, a torn left medial meniscus, and a near bone-on-bone, degenerative condition. Dr. Brooker performed left knee arthroscopic surgery in March 2009.

Following that surgery, Petitioner had stiffness, tenderness and radiating symptoms in his left leg, which Dr. Brooker suspected were emanating not from his knee, but from his back. He referred Petitioner to a pain specialist and to a spine surgeon. Although Dr. Brooker requested Petitioner return to him for further care after that, Petitioner did not. In May 2015, Petitioner did return to Dr. Brooker; then, he complained of bilateral knee pain. Dr. Brooker's diagnosis at that time was arthritis. Dr. Brooker gave these opinions: Petitioner's work injury caused a meniscus tear; it did not cause his degenerative arthritis; Petitioner had persistent lumbar radiculopathy; and possibly, CRPS or RSD. On cross-examination, Dr. Brooker admitted he did not check Petitioner for other symptoms of CRPS or RSD. Dr. Brooker opined Petitioner's left knee condition was an

aggravation or acceleration of his work injury and a preexisting condition. He believed Petitioner has required restrictions for his left knee since September 8, 2009, despite not having seen him for a 5½ year period since then. Dr. Brooker recommended no treatment for either of Petitioner's knees.

Dr. Goldberg, Respondent's Section 12 expert, testified that he conducted five (5) examinations of Petitioner. The first, on August 31, 2009, was difficult because Petitioner was uncooperative. Dr. Goldberg's diagnoses at that time were: severe preexisting arthritis of the left knee; low back arthritis without herniation or nerve compression, and non-anatomic pain complaints over multiple areas of the knee. Dr. Goldberg opined Petitioner's work injury did not cause his condition and pain, and he found no anatomical basis or physical reason to prevent Petitioner from returning to work.

Petitioner's complaints to Dr. Goldberg at his January 2010 examination were similar to those made at his first exam. Dr. Goldberg found Petitioner had positive Waddell's signs and possible symptom magnification or secondary gain. Dr. Goldberg also found Petitioner had non-physiologic pain responses at that exam, and he opined Petitioner was at MMI and able to work full duty based upon his anatomic findings.

Following examinations in September 2010, November 2011 and February 2015, Dr. Goldberg found Petitioner to be at maximum medical improvement and able to work full duty from an anatomical standpoint. In November 2011, Dr. Goldberg found no objective orthopedic explanation for Petitioner's "condition," and he reported that Petitioner was at MMI and able to work full duty from an orthopedic and anatomical basis. At Dr. Goldberg's February 6, 2015 examination of Petitioner, he opined he needed no further treatment and that it would be extremely unlikely that further surgery would improve his condition.

Medical records in evidence include a June 22, 2009 physical therapy report which noted that: Petitioner was able to navigate stairs with less difficulty; he had walked 3 to 4 blocks the day before, and he achieved 104 degrees of knee flexion. A November 24, 2009 report of Dr. Lim documented Petitioner's chief complaint to be low back pain, not knee pain. An October 2010 report of Dr. Lim noted that he found Petitioner's knee MRI to be essentially unremarkable; Dr. Lim considered Petitioner's pain source to be an L3-L4 herniation. Dr. Lim's October 25, 2012 report showed he released Petitioner to return to modified duty with restrictions, for four hours per day. On January 11, 2013, Dr. Lim recommended Petitioner continue to work at a light duty level.

Conclusions:

The Commission finds Petitioner's credibility lacking. Not only did Petitioner fail to disclose all of his prior health conditions to his treaters, but his testimony conflicted with the histories in his medical records and the testimony of other witnesses. Petitioner testified he felt low back pain right after his fall; emergency room records fail to document any low back complaints or symptoms. Petitioner testified that his Section 12 exams by Dr. Goldberg were cursory, and that the doctor just looked at him; Dr. Goldberg reported Petitioner was uncooperative at his exams, and he noted positive Waddell's signs.

Petitioner also made misrepresentations to Dr. Harsoor. On six separate visits between February 2014 and April 2015, he reported having a "gait disturbance," while on five of those visits, Dr. Harsoor examined him and reported that his gait was normal. Dr. Harsoor found Petitioner's bilateral lower extremity motor strength to be 5/5 and his neurology sensation, normal. At office visits in July 2014 and January 2015, Petitioner told Dr. Harsoor he was not on workers compensation; in fact, at those times his workers' compensation claim was pending and he was receiving TTD benefits.

With regard to Petitioner's left knee condition, the Commission finds Petitioner proved he sustained a torn left knee meniscus and a temporary aggravation of pre-existing degenerative arthritis as a result of his work accident. His knee treatment through September 8, 2009 was reasonable, necessary and causally related to his work accident. The Commission finds that any aggravation or exacerbation of Petitioner's pre-existing degenerative arthritis which was caused by his work accident was temporary, and had been resolved by September 8, 2009. On that date Petitioner reached maximum medical improvement for his left knee injury. The Commission finds Petitioner's left knee condition and need for any treatment or surgery after September 8, 2009 to not be related to his work accident, but rather, to his severe, pre-existing, near bone-on-bone degenerative arthritis.

The Commission bases its conclusions on Dr. Brooker's report that the arthroscopic debridement surgery was effective and that Petitioner's knee improved thereafter. Although Petitioner continued complaining of knee pain after his arthroscopic surgery, he became less compliant with physical therapy. In September 2009, Dr. Brooker requested Petitioner return to see him after seeing a spine surgeon, but Petitioner never did. When Petitioner finally did return to see Dr. Brooker over five years later, it was for treatment of bilateral, degenerative knee arthritis. Dr. Goldberg found Petitioner able to work following his August 31, 2009 exam. He noted Petitioner's knee complaints were non-anatomical, and his complaints of pain were out of proportion with the findings. The Commission finds Dr. Goldberg's opinions credible.

The Commission finds unpersuasive Dr. Brooker's opinion that Petitioner developed left leg CRPS or RSD. No other doctors corroborated that diagnosis including Dr. Gandhi, the pain management specialist to whom Dr. Brooker referred Petitioner. Dr. Brooker admitted he hadn't checked Petitioner for other symptoms of CRPS or RSD, and that Petitioner may simply have been "very sensitive." Dr. Brooker's records contain no documentation of signs or symptoms of CRPS or RSD.

The Commission agrees with the Arbitrator that Petitioner established causation as to his low back and left-sided radicular condition, for the reasons stated in the Arbitration decision. The Commission finds Petitioner reached maximum medical improvement for his low back injury on January 11, 2013. His back treatment and surgery through that date were reasonable, necessary and related. As noted by the Arbitrator, Petitioner's back condition had stabilized by that date.

Although the Arbitrator was inaccurate in finding that Dr. Goldberg opined Petitioner's prostate cancer was the cause of his current condition and any inability to work– he did not – the Commission does not consider that finding to be grounds for reversal. Dr. Goldberg did report Petitioner's *pain* could have been caused by a prostate cancer recurrence, among other possible

causes. Those include: a psychological problem, symptom magnification/secondary gain, nonphysiologic sources and Petitioner's intervening injury in July 2011. The Commission finds persuasive Dr. Goldberg's opinion that any inability of Petitioner to work after January 11, 2013 was not related to his work accident.

The Commission agrees with the Arbitrator that Dr. Brooker's retroactive work restrictions lacked sufficient foundation and were not credible. Dr. Brooker had not treated Petitioner for 5½ years, yet purported to find restrictions appropriate during that entire time. He was unaware of Petitioner's other health conditions, which might have changed his opinions. Two physicians found Petitioner demonstrated positive Waddell's signs. Dr. Brooker did not check for Waddell's signs, and he based his opinions largely upon Petitioner's subjective complaints, which the Commission finds exaggerated and questionable. While the Commission agrees that Petitioner was not required to undergo a functional capacity evaluation as a prerequisite to receiving permanent work restrictions, that is a factor to which the Commission has given weight.

The Commission finds Petitioner has not proven entitlement to maintenance benefits after January 11, 2013. In so finding, the Commission relies on Dr. Goldberg's opinions, following each of his exams, that there was no reason why Petitioner could not work. The Commission also bases its conclusions upon Petitioner's lack of credibility. Finally, the Commission bases its conclusions on Dr. Lim's testimony that he had no opinion whether Petitioner currently requires restrictions.

> On November 4, 2011 Dr. Goldberg wrote the following:
> "Based on how the patient's *(sic)* walks in clinic, I cannot imagine him able to walk, work or drive a bus. He appears even unable to sit. However, on an anatomical basis, I do not find an objective orthopedic support to explain that. On an orthopedic and anatomical standpoint he should be able to work full duty."

The Commission does not consider the above to be a "restriction" that Petitioner should never walk, work or drive a bus; but rather, his belief that Petitioner's complaints were inconsistent with his physical examination and with his medical records.

The Arbitrator found Petitioner's subsequent intervening accident of July 2011 did not affect his condition after that date, because she believed the radiographic studies taken thereafter did not show any new disc pathology. The Commission views the evidence somewhat differently. The lumbar MRI taken on August 15, 2011 did report posterior displacement of the L3 nerve root, a finding not documented on any of Petitioner's three MRI's taken before his intervening injury. Further, Dr. Lim reported that Petitioner's April 2012 lumbar MRI showed, "disc degeneration at the L3-L4 level and x-rays show vertical instability with collapse of his disc space at the L3-L4." That also was a new finding which was not noted on Petitioner's previous film studies. Prior to the July 2011 intervening injury, Petitioner's recovery from his February 2011 lumbar surgery had been going well. Dr. Lim reported it had been successful in relieving Petitioner's symptoms, and he noted that Petitioner was, "definitely dramatically better." The increase in Petitioner's pain and symptoms, and the recommendation for a second back surgery occurred after Petitioner's July 2011 injury.

The Commission finds that any inability of Petitioner to work without restrictions is due not to his December 15, 2008 work accident, but to his unrelated medical conditions, some of which he did not disclose to his treating physicians.

With regard to medical expenses, the Commission affirms and adopts the Arbitrator's award except for those expenses incurred for treatment relating to Petitioner's left knee after September 8, 2009. The Commission finds the left knee treatment received after September 8, 2009 to not be causally related to his work injury. The Commission also affirms and adopts the Arbitrator's denial of medical bills incurred for treatment of Petitioner's right knee and prostate cancer, which it finds were not proven related to Petitioner's work injury.

With regard to temporary total disability benefits, the Commission affirms and adopts the Arbitrator's award of benefits between December 16, 2008 and January 11, 2013, representing 212-3/7 weeks. Other than Dr. Brooker's opinion that Petitioner required restrictions as a result of his work injury, which opinion the Commission has found not credible, Petitioner presented no medical opinion that he was unable to work full duty after January 11, 2013. At his November 2015 deposition, Dr. Lim admitted he had no opinion of Petitioner's current condition and no idea whether Petitioner required restrictions, since he hadn't seen Petitioner since January 2013. On February 6, 2015, Dr. Goldberg again reported he found no reason why Petitioner could not work full duty.

The Commission affirms and adopts the Arbitrator's award of 35% loss of use of his left leg for his knee injury and 25% loss of use of person-as-a-whole for his low back injury. In declining to make an award under §8(d)1, the Commission finds Petitioner failed to prove he became partially incapacitated from pursuing his usual and customary employment, or that he suffered an impairment of earnings as a result of that incapacitation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 20, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits is modified as stated hereinabove.

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.

18IWCC0389

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 15 2018

o-04/25/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DIXON, ISAAC
Employee/Petitioner

Case# **09WC025643**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

18IWCC0389

On 9/20/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1505 SLAVIN & SLAVIN LLC
DAVID VanOVERLOOP
100 N LASALLE ST 25TH FL
CHICAGO, IL 60603

0515 CHICAGO TRANSIT AUTHORITY
LAURA HARTIN
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Isaac Dixon
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # **09** WC **25643**

Consolidated cases: **N/A**

18IWCC0389

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **7/22/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/15/08**, 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.

For the reasons set forth in the attached decision, the Arbitrator finds Petitioner established causation as to left knee and lower back conditions that required surgery.

In the year preceding the injury, Petitioner earned **$55,889.60**; the average weekly wage was **$1,074.80**.

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

Petitioner ***has in part*** received all reasonable, related and necessary medical services.

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

Respondent shall be given a credit of **$222,258.82** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$222,258.82**.

Respondent is entitled to a credit of **$23,629.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $716.53/week for 212 3/7 weeks, commencing December 16, 2008 through January 11, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay the following reasonable and necessary medical expenses, subject to the fee schedule: 1) Advocate Medical Group, $455.00; 2) PTSIR, $6,325.00; 3) Advocate Christ Hospital, $23,629.00; 4) Midland Orthopedics, $586.21; 5) High Tech Medical, $6,707.00; 6) St. Margaret Mercy, $559.26; and 7) Neurologic Associates, $900.00. See further details in the attached decision.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established permanency equivalent to 35% loss of use of his left leg under Section 8(e), equivalent to 75.25 weeks, and an additional 25% loss of use of the person as a whole under Section 8(d)2 of the Act, equivalent to 125 weeks. The Arbitrator awards permanency at the weekly rate of $644.88 based on the stipulated average weekly wage.

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

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

9/16/16
Date

SEP 20 2016

Isaac Dixon v. Chicago Transit Authority
09 WC 25643

Summary of Disputed Issues

The parties agree Petitioner sustained an accident on December 15, 2008 while working as a bus operator for Respondent. They also agree Petitioner was temporarily totally disabled from December 16, 2008 through September 2, 2009. The disputed issues include causal connection, medical expenses, additional weekly benefits from September 3, 2009 through the July 22, 2016 hearing and nature and extent, with Petitioner claiming permanent total disability. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified he began working as a bus operator for Respondent in 2000. He worked full-time, picking up and transporting passengers. He was a union employee, earning $26.87 per hour as of the accident.

Petitioner testified he was in good health as of December 15, 2008. He denied injuring or having problems with his back or left leg before that date.

Petitioner testified that, shortly before his accident, he was operating a bus along a designated route when he smelled fumes. After he turned left from 95th onto Halsted, the fumes became stronger. As he approached 119th, he saw smoke at the rear of the bus, pulled over and directed his passengers to exit. He placed a call to his dispatcher and went to the back of the bus to get a fire extinguisher. As he was beginning to exit the bus, he became disoriented, due to the fumes, and fell. He lost consciousness. When he came to, paramedics were assisting him. He felt pain in his low back and left knee. His knee pain was worse than his back pain.

Petitioner testified that the paramedics transported him from the accident scene to the Emergency Room at MetroSouth Medical Center. The Emergency Room records reflect that Petitioner complained of left knee pain and lightheadedness secondary to fume inhalation at work. An initial nursing history provides further detail:

> "Pt states he was driving a CTA bus when he 'smelled something like burning leaves that smelled really strong.' Pt states that since then he has had a bad headache with nausea and vomiting. Pt states that he vomited x1. Also c/o left knee pain. Pt states, 'I think I fell.' "

On left knee examination, the Emergency Room physician noted a full range of motion and mild tenderness. He ordered X-rays of the left knee and chest. The chest X-rays showed no infiltrates. The left knee X-rays revealed degenerative changes and no fractures.

The Emergency Room physician discharged Petitioner early in the morning on December 16, 2008 with instructions to stay off work two days and follow up with Dr. Iqbal. PX 1.

Respondent offered into evidence the following accident-related documents: 1) a "speed letter" dated December 15, 2008 indicating that a bus repairman detected no fumes on the bus but "did

find damage to brake line, which was dragging by tire area," with the comment that it was possible the brake lines were frozen and caused the problem; 2) a "Special Occurrence Report" signed by a Respondent manager, Patrick Sachell, indicating that, at the accident scene, Petitioner reported smelling fumes and striking his left knee on a pole upon exiting the bus – Sachell also indicated that, as of December 28, 2008, after further investigation, Petitioner was not found to be in violation of any Respondent rules or standard operating procedures; and 3) an "Employee's Report of Injury on Duty" signed by Petitioner at 5:30 AM on December 16, 2008 indicating that, two hours into his shift, he smelled fumes, became lightheaded and hit his left knee "when off the bus on ground." On this form, Petitioner reported having previously undergone right knee surgery. RX 1.

Petitioner testified he underwent drug testing after the accident and followed up at Concentra after being discharged from MetroSouth. The Concentra records (PX 2) reflect that Petitioner saw a physician's assistant, Grace Cartwright, on December 17, 2008. The records reflect Petitioner sustained a work accident at 3:45 PM on December 15, 2008. They set forth the following patient statement: "slip[ped] and hit my left knee on pole." They also set forth a more detailed history:

> "56 y.o. male c/o lower back pain and left knee pain. Patient states he slipped on ice and hit left knee against pole, twisting his left knee and lower back in the process. Incident occurred approximately 4:00 PM on 12/15/08. . . . The mechanism of injury was a slip on ice, landing on the left leg. The patient twisted left knee and lower back. The pain began immediately."

The records also reflect a history of a prior right knee arthroscopy.

On left knee examination, Cartwright noted moderate tenderness anteriorly at the distal femur at the patellar tendon, a moderate limp, an inability to squat or bear weight, a full range of motion with pain on extension and flexion, no swelling or ecchymosis and negative McMurray's testing. On lower back examination, she noted moderate tenderness of the right lumbar spine near L5, pain with range of motion testing, negative bilateral leg raising and negative Waddell's. She diagnosed a lumbar strain and a left knee contusion and strain. She prescribed medication and physical therapy. She released Petitioner to light duty with no lifting over 5 pounds, no prolonged standing or walking, no bending more than ten times per hour, no pushing/pulling over 10 pounds and no squatting, kneeling or climbing. She indicated Petitioner was unable to drive or operate machinery. She directed Petitioner to return on December 19, 2008 but noted that Petitioner opted to follow up with his personal physician. PX 2.

On December 22, 2008, Petitioner saw Dr. Sheela Manaparambil at Advocate Health Centers. The brief handwritten note from that date reflects that Petitioner complained of left leg and back pain. On examination, the doctor noted negative straight leg raising. She also noted a history of prostate cancer. She recommended that Petitioner continue taking pain medication. PX 3.

Petitioner returned to Dr. Manaparambil on January 5, 2009 and complained of back and left knee pain secondary to falling at work in December. A handwritten history describes Petitioner as having fallen "on knee." The doctor obtained lumbar spine and left knee X-rays. She described the films as showing degenerative changes. She prescribed an Ace bandage. PX 3.

On January 19, 2009, Petitioner saw Dr. Manaparambil again and complained of left knee pain. The doctor noted left knee swelling on examination. She prescribed Tylenol #3 and recommended an orthopedic consultation. PX 3. Petitioner saw Dr. Brooker at Midland Orthopedic Associates the same day. Dr. Brooker indicated that, a month earlier, Petitioner fell at work, injuring his left knee and lower back. On examination, he noted positive straight leg raising, a positive medial McMurray test, a mild effusion and no instability within the knee. He expressed concern that Petitioner "presently has signs and symptoms of meniscus tear on the medial side of the knee as well as lumbar radiculopathy affecting the left lower extremity." He prescribed left knee and lumbar spine MRI scans and took Petitioner off work, indicating Petitioner's work status would depend on the results of the MRIs. PX 11.

The left knee MRI, performed on January 30, 2009, showed an obliquely-oriented tear in the posterior horn and body of the medial meniscus, moderate medial tibiofemoral compartment arthrosis with severe near full-thickness thinning of articular cartilage, mild to moderate chondromalacia in the patellofemoral joint compound, a small joint effusion and a questionable low-grade medial collateral ligament sprain. The lumbar spine MRI, performed the same day, showed mild degenerative changes at L3-L4 and superimposed small broad-based far left lateral disc protrusion at L3-L4 not clearly impinging on any adjacent neural structures. PX 11.

On February 4, 2009, Dr. Brooker interpreted the left knee MRI as showing "close to bone against bone changes with medial meniscus tear on top of that." He opined that the work accident caused a "significant exacerbation of meniscal pathology." He interpreted the lumbar spine MRI as showing "minimal nerve root impingement." He felt Petitioner's back "should do well with therapy of the knee." He injected the knee and directed Petitioner to begin physical therapy. PX 11.

Petitioner underwent an initial physical therapy evaluation at PTSIR on February 10, 2009. The evaluating therapist, Dan Lang, G.P.T. (hereafter "Lang"), indicated that Petitioner reported slipping on ice at work on December 15, 2008 and experiencing a pop in his left knee along with low back pain. Lang noted that Petitioner denied any prior left knee or low back problems and complained of persistent left knee and low back pain as well as buckling of the left knee while descending stairs. PX 11.

Petitioner continued attending therapy thereafter through March 17, 2009, with Lang describing him as being able to tolerate only minimal activity. Lang discharged Petitioner from care on March 17, 2009 secondary to left knee surgery scheduled for March 24, 2009.

On March 24, 2009, Dr. Brooker performed a left knee arthroscopy. In his operative report, he documented Grade 2 chondromalacia of the trochlea, a complex tear of the posterior horn of the medial meniscus and mild Grade 1 chondromalacia of the medial femoral condyle. He described the anterior cruciate ligament as intact. PX 11.

Petitioner testified the surgery did not help. He still had to use a cane afterward.

On April 1, 2009, Dr. Brooker removed the surgical sutures and prescribed therapy. Petitioner resumed therapy with Lang on April 8, 2009. On that date, Lang described Petitioner as having decreased to one crutch recently and displaying "extreme muscle guarding." Petitioner attended therapy on an irregular basis thereafter until May 8, 2009, with Lang noting a number of cancellations and "very limited tolerance for joint mobilization or passive range of motion." PX 11.

On May 11, 2009, Dr. Brooker noted ongoing left knee complaints as well as persistent radicular symptoms, positive straight leg raising and some quadriceps weakness. He indicated Petitioner was still using crutches and would require assessment by a pain specialist in order to make any progress. He administered another injection. PX 11.

On June 8, 2009, Dr. Brooker indicated that Petitioner's knee was "not the sensitive area any longer" and that the low back seemed to be the primary problem. He started Petitioner on Lyrica "to prevent him from getting any longer term neurologic issues such as RSD." He noted that Petitioner was scheduled to see a pain specialist in a few days. PX 11.

Petitioner saw Dr. Gandhi, a pain management physician, on July 9, 2009. In his note of that date, the doctor indicated that Petitioner complained of left knee, lower back and radiating left leg pain secondary to a fall in December. He also indicated that Petitioner reported obtaining relief from left knee surgery but was still experiencing 9/10 pain down the back of his left leg into his ankle. On examination, Dr. Gandhi noted 5/5 strength in the right leg. He was unable to test the strength of Petitioner's left leg due to "severe guarding." He noted decreased sensation over the left L5-S1 dermatomes, compared with the right, and positive straight leg raising on the left only. He interpreted the lumbar spine MRI as showing mild degenerative changes at L3-L4 and a small, broad-based far left lateral disc protrusion at the same level. He recommended an epidural steroid injection.

On July 13, 2009, Dr. Brooker noted that Petitioner had recently seen a pain specialist who was recommending an epidural injection. He agreed with this recommendation. He noted that Petitioner was not tolerating the Lyrica very well. He instructed Petitioner to return in three weeks and noted that Petitioner would "probably be off work for at least another 6 to 8 weeks." PX 11.

Petitioner saw Dr. Brooker again on August 17, 2009. The doctor noted that Petitioner was still experiencing "significant hypersensitivity and radiculopathy on [the left] side" and was also "starting to get significant limitation of motion." He started Petitioner on Norco and Neurontin. He directed Petitioner to return in three weeks and expressed hope that the pain treatment would be authorized. PX 11.

At Respondent's request, Petitioner saw Dr. Benjamin Goldberg, an orthopedic surgeon, for purposes of a Section 12 examination on August 31, 2009. In his lengthy report of September 2, 2009 [Goldberg Dep Exh 3], the doctor recorded a history of the accident, indicating Petitioner became dizzy due to fumes on his bus, got off the bus, lost consciousness and was on the ground, receiving assistance from fire department personnel, when he came to. He noted that Petitioner went to MetroSouth Medical Center's Emergency Room the same day, with personnel there recording complaints of fume inhalation, lightheadedness, one episode of vomiting and left knee pain but making no mention of the back. He also noted that, two days later, a physician's assistant at Concentra describing Petitioner as slipping and hitting his left knee on a pole. He also reviewed records from Drs. Manaparambil, Brooker and Gandhi.

Dr. Goldberg described Petitioner as wearing glasses and a Bluetooth headset. He indicated that Petitioner exhibited an unusual gait, with no left knee flexion but no shortened stance phase, and was unwilling to attempt to walk on his toes or heels. He indicated that Petitioner had great difficulty getting onto his examination table but flexed his knee to 90 degrees once he was actually sitting on the table. He described Petitioner as very reluctant to flex or extend his knee and complaining of diffuse left knee and back pain. He also noted a complaint of subjective decreased sensation over the left leg.

Dr. Goldberg opined that the accident possibly caused an "exacerbation of medial meniscus tear on top of pre-existing arthritis." He characterized the left knee surgery as reasonable but unhelpful, noting that Petitioner felt his pain was worse now. He described Petitioner's left knee pain as "out of proportion with the findings, mostly with the locations of tenderness." He was unsure as to why Petitioner was experiencing so much back pain, given the MRI, "which apparently does not show any nerve compression per the interpretation of Dr. Brooker and Dr. Gandhi." He conceded he lacked the lumbar spine MRI report but indicated that, barring any demonstration of a herniated disc, Petitioner was "essentially at maximum medical improvement." He further opined that Petitioner "should be anatomically capable of working full duty." He indicated that, if Petitioner was indeed suffering left knee pain, it was due to pre-existing arthritis rather than the work injury.

On September 8, 2009, Dr. Brooker noted that work had not authorized the pain management. He recommended that Petitioner see a spine surgeon. PX 11.

On September 15, 2009, Petitioner sought treatment at St. Margaret Mercy Healthcare's Emergency Room. Hospital personnel recorded a history of the work accident and noted Petitioner reported experiencing left knee and back pain since that accident. They also noted that Petitioner had experienced an episode of left leg weakness, with associated back pain, earlier that morning. They administered a Toradol injection and advised Petitioner to continue taking his regular pain medication and see Dr. Brooker in follow-up. PX 23.

Based on limited records in PX 3, it appears that, on September 30, 2009, Dr. Manaparambil took Petitioner off work for one month and recommended EMG testing secondary to lumbar radiculopathy. No accompanying office note is in evidence.

On November 24, 2009, Dr. Lim obtained a history of the work accident and evaluated Petitioner. He described straight leg raising as positive only for back pain. He noted 2/5 positive Waddell's signs and a range of motion of zero. He described Petitioner as "unable to cooperate with physical exam to assess range of motion because of pain." He ordered a repeat MRI and continued the pain medication.

On January 15, 2010, Dr. Lim interpreted the repeat MRI as showing a far lateral disc herniation at L3-L4. He discussed both therapy and epidural injections with Petitioner, noting that Petitioner wanted to try therapy first. He kept Petitioner off work and prescribed Norco 10. PX 27.

At Respondent's request, Dr. Goldberg re-examined Petitioner on January 22, 2010. In his lengthy report of January 25, 2010 (Goldberg Dep Exh 4), the doctor indicated he reviewed more recent records, including Dr. Manaparambil's September 30, 2009 note, Dr. Lim's initial note of October 24, 2009 and the recent lumbar spine MRI report. He noted that Petitioner remained off work per Dr. Lim.

Dr. Goldberg reiterated, verbatim, his previous description of Petitioner's gait and difficulty getting onto the examination table. He again found Petitioner to be at maximum medical improvement and capable of full duty "as he has no definite mechanical source of his pain."

On February 19, 2010, Dr. Lim noted that Petitioner denied any improvement secondary to therapy. He discussed injections and surgery, noting that Petitioner wanted to try injections first. PX 27.

On March 2, 2010, Dr. Manaparambil noted improvement of Petitioner's left knee pain following surgery but persistent lower back pain radiating down the left leg to the lateral half of the left ankle. She indicated that Petitioner rated this pain at 9/10 and reported taking Vicodin, Ibuprofen and Flexeril. She noted that Petitioner requested a referral for pain management. She ordered various laboratory studies, renewed the medication and referred Petitioner to Dr. Cupic for pain management. PX 4.

On May 18, 2010, Dr. Manaparambil again noted "chronic low back and knee pain." PX 3.

Dr. Kim administered left L5 epidural steroid injections on April 19 and June 7, 2010. PX 27.

On June 18, 2010, Dr. Kim noted some improvement from the injections and prescribed a third. PX 27.

Petitioner testified the first injection helped somewhat but his symptoms returned.

On July 12, 2010, Dr. Manaparambil noted that Petitioner's low back and knee pain was better and that he was still seeing an orthopedist. PX 3.

Dr. Kim performed a third left L5 epidural steroid injection on July 26, 2010. PX 27.

On August 13, 2010, Dr. Kim noted no significant improvement. She refilled Petitioner's medication. She directed Petitioner to stay off work and return to Dr. Lim. PX 27.

Petitioner returned to Dr. Lim on September 10, 2010 and denied improvement. The doctor's note reflects that Petitioner reported "getting back onto his crutches because of the severity of the pain and the weakness in his lower extremity." On examination, the doctor noted very markedly positive left-sided straight leg raising. He recommended another lumbar spine MRI. PX 27.

At Respondent's request, Dr. Goldberg re-examined Petitioner on September 17, 2010. In his lengthy undated report (Goldberg Dep Exh 5), he reiterated, verbatim, his previous description of Petitioner's gait and behavior. He also noted that Petitioner complained of "severe pain with trunk rotation, head and shoulder compression." He indicated that Petitioner apparently had undergone three epidural injections between May and June of 2010 but that he lacked the reports concerning this care.

Dr. Goldberg diagnosed the following: 1) severe pre-existing left knee arthritis; 2) severe right knee pain; 3) non-anatomic back pain; 4) a significant history of narcotic use and potential dependence; and 5) non-anatomic pain complaints over multiple areas of the knee, along with multiple non-anatomic symptoms, "such as a non-shortened stance phase." He indicated that the "way [Petitioner] sits in a chair exacerbates his back pain." He further indicated that Petitioner "may have a far lateral disc herniation at L3-L4," as documented by Dr. Lim, but that Dr. Lim did not mention which side this herniation was on. He described the epidural injections as "reasonable" but not providing relief. He stated that Dr. Lim "wants another MRI, reportedly before considering surgery." He stated this was "unlikely to be helpful," noting that Petitioner had already undergone two MRIs. He conceded he had not seen the latest MRI. He indicated Petitioner's pain could be due to severe pre-existing knee arthritis but stated that Petitioner "does not behave like a typical patient with arthritis of the knee the way he

walks and/or sits." He indicated Petitioner might need a knee replacement but stated this was non-occupational.

Dr. Goldberg addressed Dr. Lim's surgical recommendation as follows: "given his significant non-anatomic pain, it is unlikely, but theoretically possible (less than 25% in my opinion), that surgery will help his back pain and return him to function." He immediately went on to say that "there is no anatomical explanation of his multiple back pain complaints." He again found Petitioner to be at maximum medical improvement and capable of full duty.

On September 22, 2010, Sedgwick CMS sent Dr. Lim a letter stating that, based on its investigation, Petitioner was "no longer eligible for benefits" and that it would not pay for any more treatment. PX 27.

Petitioner underwent a repeat left knee MRI on October 4, 2010. The radiologist noted a Grade III increased signal in the posterior horn of the medial meniscus, intact lateral meniscus and ligaments, moderate medial compartment degenerative changes and mild patellofemoral degenerative changes. PX 27.

On October 15 and November 3, 2010, Dr. Lim noted ongoing complaints and discussed the possibility of surgery. He noted that Petitioner expressed a desire to undergo another trial of therapy. PX 27.

On November 19, 2010, Dr. Lim noted that Petitioner "would like to proceed with surgery but would like to wait until January." The doctor recommended that Petitioner continue therapy until then. PX 27.

On December 22, 2010, Dr. Lim met with Petitioner to discuss the risks associated with a microdiscectomy at L3-L4. PX 27.

Dr. Lim performed a microdiscectomy at L3-L4 at Christ Hospital on February 17, 2011.

On March 4, 2011, Dr. Lim noted that Petitioner reported improvement but was still experiencing some left leg pain. He prescribed physical therapy. PX 29.

Petitioner began a course of therapy at PTSIR on March 14, 2011. The evaluating therapist noted that Petitioner complained of back and left leg pain and was "using a single point cane at all times." PX 29.

On April 29, 2011, Dr. Lim noted that Petitioner was "definitely dramatically better" but was still experiencing occasional discomfort. He recommended that Petitioner continue therapy and return in three months. PX 29.

On May 18, 2011, Dr. Manaparambil noted that Petitioner complained of left knee pain causing him to limp as well as "low back pain aggravated by walking." On examination, she noted a limp and mild left knee swelling. She renewed Petitioner's Hydrocodone prescription. PX 3.

On June 1, 2011, Dr. Lim indicated Petitioner was still experiencing left leg pain. He ordered a repeat lumbar spine MRI and an EMG. He discontinued physical therapy. PX 29.

Petitioner underwent the repeat lumbar spine MRI on August 15, 2011. The radiologist compared the results with the previous MRI of October 2010. He noted "no metastatic prostate cancer to the lumbar spine" along with "enhancing epidural fibrosis at the site of left laminectomy six months ago" and a "persistent left foraminal and far lateral disc protrusion at L3-L4" causing moderate left foramen stenosis and posterior displacement of the left L3 nerve root. PX 3.

Petitioner underwent EMG testing on August 17, 2011. Dr. Itkin, a neurologist, performed this testing. He noted that Petitioner had undergone lumbar spine surgery in February and was complaining of both left knee pain and pain radiating down the left leg. On examination, he noted negative straight leg raising and "patchy sensory deficit over the left lower extremity without obvious neuropathic anatomic distribution." He found no evidence of peripheral neuropathy but noted evidence of a "possible L3 root dysfunction," as evidenced by "membrane instability in the left adductor magnum." He indicated this finding needed to be clinically correlated, given the absence of other thigh muscle involvement. PX 3.

Petitioner returned to Dr. Lim on August 26, 2011, with the doctor noting the recent MRI and EMG results and recording the following interval history:

> "He was improving after surgery until about a month ago and he had some injury and all his pain has returned. He states it is basically the same as it was before surgery. I discussed further options with him, possibly even open decompression."

The doctor noted that Petitioner expressed a preference for "rehab for a month" before deciding whether to undergo more surgery. PX 3.

On October 28, 2011, Dr. Lim noted that Petitioner denied improvement and expressed a desire to undergo another injection. The doctor prescribed an injection and Norco. He continued to keep Petitioner off work. PX 30.

Petitioner returned to Dr. Lim on January 6, 2012 and reported pain in his back and left leg that had worsened during the preceding months. The doctor discussed the idea of additional surgery and noted that Petitioner wanted to think about it and bring his wife along to a future visit. The doctor directed Petitioner to remain off work. PX 30.

On February 6, 2012, a certified medical assistant at Advocate Medical Group noted that Petitioner was scheduled to see Dr. Lim and was planning to undergo additional back surgery. PX 3, 6.

Petitioner underwent another lumbar spine MRI on April 5, 2012. The radiologist compared the results with the MRI performed on August 15, 2011. He again noted mild enhancing epidural fibrosis at L3-L4 and moderate left foramen stenosis at the same level. He described the loss of disc height at L3-L4 as mild and "unchanged from August 15, 2011." PX 6.

On April 6, 2012, Dr. Lim reviewed the MRI results with Petitioner and discussed additional surgery, i.e., a decompression with fusion and instrumentation at L3-L4. PX 31.

On June 29, 2012, Dr. Lim met with Petitioner and his wife to discuss the cancellation of the proposed surgery. He indicated that Petitioner cancelled the surgery because he was concerned it would not allow him to return to work. He recommended that Petitioner obtain a second opinion from Dr. Rinella. He continued to keep Petitioner off work. PX 31. [It is not clear whether Petitioner ever saw Dr. Rinella.]

Petitioner returned to Dr. Lim on September 19, 2012 and indicated he was ready to proceed with surgery. PX 31.

On October 19, 2012, Dr. Lim noted that surgery was scheduled for November 5, 2012 but that Petitioner reported having received a letter telling him he would be fired if he did not return to work. The doctor released him to light duty four hours per day. PX 31.

Petitioner returned to Dr. Lim on January 11, 2013 and reported having been fired. Petitioner indicated he had decided against further surgery and was "considering applying for total disability." The doctor indicated he explained he was not sure whether Petitioner met the qualifications for total disability. He stated Petitioner "should be able to continue to work at a light duty level." He released Petitioner from care on a PRN basis. PX 31.

Petitioner testified he did not undergo the additional surgery proposed by Dr. Lim because his personal care physician did not recommend it. He did not return to Dr. Lim after January 11, 2013.

Petitioner testified he last received temporary total disability benefits in February 2014. [Respondent maintains it continued paying benefits through January 8, 2015. Arb Exh 1.]

Between February 2014 and January 2015, Petitioner underwent treatment with Dr. Harsoor, a pain management physician, with the doctor prescribing Tramadol and performing drug screenings. At the initial visit, the doctor described Petitioner as very weak, unable to sit and repeatedly changing his posture. At other visits, the doctor noted that Petitioner was experiencing dizziness and/or blackouts and was utilizing a cane or walker. On April 22, 2015, the doctor refilled Petitioner's Hydrocodone prescription. PX 32-33.

A repeat lumbar spine MRI performed on November 21, 2014 showed various post-operative changes as well as a "non-specific, approximate 0.8 cm diameter ovoid focus of decreased T1 and intermediate T2 weighted signal and mild enhancement, located within the left iliac wing." The radiologist thought this might represent an atypical hemangioma. He recommended a follow-up study in six months. PX 10.

Dr. Goldberg re-examined Petitioner on February 6, 2015. See below.

Petitioner returned to Dr. Brooker on May 29, 2015. On that date, the doctor noted complaints of bilateral knee pain, with associated difficulty walking, and "pretty significant lumbar radiculopathy." He obtained standing X-rays, which showed medial joint space narrowing and osteophyte formation in both knees. He injected the left knee and directed Petitioner to return in one week to have the other knee injected. He imposed a restriction of "weight bearing as tolerated" and recommended that Petitioner see a spine surgeon. PX 13. On June 26, 2015, Dr. Brooker injected the right knee and directed Petitioner to return to him after seeing a spine surgeon. PX 14.

Petitioner testified he returned to Dr. Brooker in May 2015 because he was experiencing bilateral leg pain. His left knee pain never changed significantly. The shots Dr. Brooker administered provided only temporary relief.

On September 2, 2015, Dr. Brooker noted that Petitioner obtained some relief from the knee injections. He also noted that Dr. Lim had recommended a spinal fusion but that Petitioner's primary care physician did not believe Petitioner should undergo this. He stated that Petitioner "is not a candidate for any knee surgery the way he is with his back." PX 14.

On September 9, 2015, Dr. Brooker described Petitioner's left knee as "doing better after the injection." He noted complaints relative to the right knee and injected that knee again. He directed Petitioner to return in three months. PX 14.

Dr. Goldberg testified by way of evidence deposition on September 11, 2015. RX 3. Dr. Goldberg testified he underwent fellowship training in shoulder and elbow surgery and is currently in practice at the University of Illinois. RX 3 at 6. He is board certified in orthopedic surgery. RX 3 at 7. He has some independent recollection of Petitioner. He first examined Petitioner on August 31 or September 2, 2009. On that date, Petitioner complained of pain throughout his body but predominantly in his left knee and back. RX 3 at 11. It was difficult to examine Petitioner because he did not want to sit. He was uncooperative. RX 3 at 12. Petitioner's pain was non-anatomic, based on the radiographic studies and his examination. RX 3 at 12-13.

Dr. Goldberg opined that, at most, the work accident might have caused a meniscal tear but most patients who have such tears improve after surgery. Petitioner did not improve. RX 3 at 14-15.

Dr. Goldberg acknowledged he did not address maximum medical improvement when he first saw Petitioner because he lacked the lumbar spine MRI. Petitioner might have a psychological condition but he does not believe there was a physical reason why Petitioner could not work. RX 3 at 16.

Dr. Goldberg testified he re-examined Petitioner on January 22, 2010. Petitioner's complaints on that date were "pretty similar." Dr. Goldberg testified he agreed with Dr. Lim's finding of positive Waddell's signs. Those signs meant Petitioner was not likely to improve following surgery. RX 3 at 18. Petitioner's lumbar spine MRI showed age-appropriate degenerative changes. He is not able to state when those changes occurred. RX 3 at 22. Dr. Lim made comments about possible secondary gain and symptom magnification. Petitioner did not move in a normal fashion, even for someone with back pain. Eventually, he sat but it was "very, very difficult" to get him to do so. RX 3 at 21. He viewed the treatment to date as reasonable and necessary but, with the possible exception of the knee arthroscopy, unrelated to the work accident. RX 3 at 23. Petitioner was at maximum medical improvement and should have been able to resume full duty based on his anatomic findings. RX 3 at 24.

Dr. Goldberg testified that, at the next examination, Petitioner's complaints were worse. ~~Petitioner complained of 10/10 pain but was not crying. RX 3 at 25. Petitioner was now complaining of~~ his right knee, a body part he did not claim to have injured in the work accident. RX 3 at 27. Dr. Goldbert testified he felt it unlikely Petitioner would improve if he underwent back surgery. RX 3 at 27.

Dr. Goldberg testified he next examined Petitioner on November 4, 2011. Petitioner was now complaining of 8/10 pain. Petitioner had undergone some epidural injections but described them as unhelpful. RX 3 at 28-29. Petitioner was still walking in a very unusual fashion, using a crutch. The post-

operative EMG was negative. The post-operative MRI showed normal findings for a patient who had undergone a discectomy. Petitioner should have been improving, since he had undergone the discectomy months earlier. RX 3 at 31. Dr. Goldberg continued to find Petitioner to be at maximum medical improvement and capable of full duty. RX 3 at 31-32. Based on his observations of Petitioner's unusual posture and gait, Petitioner would not be able to operate a bus but this was not due to the work accident. RX 3 at 32. There is no orthopedic explanation for Petitioner's posture and gait. RX 3 at 32-33.

Dr. Goldberg testified he last examined Petitioner on February 6, 2015. RX 3 at 33. On that date, Petitioner reported having driven to his office. This was not consistent with Petitioner leaning against a table in his examination room and stating he was unable to sit. It was also inconsistent with Petitioner being unable to flex or extend his legs. Petitioner's pain was again non-physiologic. RX 3 at 37.

Dr. Goldberg testified Petitioner continued to complain of his back and left knee. Petitioner also voiced new complaints relative to his right knee. RX 3 at 34-35. These complaints did not stem from the work accident. RX 3 at 35. He also noted that Petitioner had prostate cancer. He reviewed an MRI taken on November 21, 2014. This MRI showed some arthritis in the back and an "atypical angioma," or tumor in the pelvis. In his opinion, this tumor "could be a metastasis and should be evaluated." RX 3 at 38, 40. He believed Petitioner to be at maximum medical improvement from the work accident. RX 3 at 41. He does not know whether Petitioner will be able to return to work but he does not believe the inability to work is due to an orthopedic or anatomic issue. RX 3 at 42.

Under cross-examination, Dr. Goldberg testified he performs about five to ten independent medical examinations per year. RX 3 at 43. Of these examinations, 80% are for respondents. RX 3 at 43. He devotes the rest of his time to patient care. He performs about fifteen surgeries per week. None of these surgeries involve the back. Ten to fifteen percent involve the knee. RX 3 at 43. The vast majority involve the shoulder, elbow and body parts other than the spine and knee. RX 3 at 44. His fellowship training related to elbow and shoulder surgery. RX 3 at 44. He regularly sees patients who have back pain. RX 3 at 45.

Dr. Goldberg conceded Petitioner had a meniscal tear but indicated this tear could be traumatic or degenerative. RX 3 at 46. He also conceded he reviewed only the MRI reports and not the actual images. RX 3 at 48. When he prepares his reports, he looks at any previous reports. He copies information from previous reports if it still pertains but tries to also include new information. RX 3 at 50-51.

Dr. Lim testified by way of evidence deposition on November 17, 2015. PX 34. Dr. Lim testified he is a fellowship-trained spine surgeon. He is board certified in orthopedic surgery. Lim Dep Exh 1. He performs 250 to 300 spine surgeries annually. PX 34 at 5.

Dr. Lim did not independently recall Petitioner. He used his records to refresh his memory. PX 34 at 6. He first saw Petitioner on November 24, 2009. Petitioner reported falling and landing on the ground at work while attempting to extinguish a bus fire on December 15, 2008. PX 34 at 7. He complained of back pain radiating into his buttocks, left worse than right. He denied any prior history of back problems. PX 34 at 7.

Dr. Lim testified that, on initial examination, he noted 2/5 positive Waddell's signs, a "zero range of motion in the back" and positive straight leg raising. He found it difficult to assess Petitioner's motor strength, due to Petitioner's reported pain. He reviewed the report of the MRI performed on January 30, 2009. He prescribed another MRI and directed Petitioner to remain off work. PX 34 at 7-8. The repeat MRI revealed a far lateral disc herniation at L3-L4. At the next visit, following the MRI, he ordered epidural injections and narcotic pain medication. Petitioner did not report any improvement following the injections. As of September 10, 2010, Petitioner had deteriorated and "came in on crutches." He ordered another MRI, which showed a left-sided herniation at L3-L4 causing left L3 nerve root impingement. PX 34 at 11. He recommended surgery but Petitioner initially wanted to re-try therapy. On November 19, 2010, Petitioner told him he wanted to undergo surgery but "not until January." PX 34 at 13.

Dr. Lim testified he performed a left-sided L3-L4 microdiscectomy on February 17, 2011. Following this surgery, Petitioner reported some improvement of his leg pain. On April 29, 2011, Petitioner still had occasional discomfort but was "definitely dramatically better." He was progressing in therapy but "still had significant limitation to motion, secondary to pain." PX 34 at 14-15. He kept Petitioner off work. On June 1, 2011, he recommended another MRI and an EMG, because Petitioner was still experiencing left leg pain. The EMG showed probable left L3 radiculopathy and the MRI again showed a far left lateral disc protrusion at L3-L4. Following these tests, he discussed additional surgery with Petitioner. On October 28, 2011, he indicated Petitioner "may benefit from an open decompression and possible fusion." Petitioner instead opted for an injection and more therapy. PX 34 at 17. Subsequent X-rays showed "vertical collapse of the disc space at L3-L4." PX 34 at 19. He ordered a new MRI, which showed residual disc at L3-L4 and significant collapse at the same level. At a subsequent office visit, Petitioner told him he cancelled surgery because he was concerned that he would not be able to return to work. He told Petitioner he could not guarantee him he would be able to resume working, with or without the additional surgery. He suggested that Petitioner obtain a second opinion. He suggested that Petitioner see Dr. Rinella. PX 34 at 20. At the next visit, on September 19, 2012, Petitioner complained of 7-8/10 back and leg pain and had decided to undergo the surgery. He believes the surgery was scheduled. On October 19, 2012, he released Petitioner to light duty with lifting of 10 to 15 pounds. PX 34 at 21. On January 11, 2013, Petitioner told him he had been fired and was considering applying for total disability. He told Petitioner he was unsure that he met the qualifications for total disability but that he did not have training in impairment rating. PX 34 at 21. He has not seen Petitioner since January 11, 2013. PX 34 at 21.

Dr. Lim found a causal relationship between the work accident and Petitioner's L3-L4 disc herniation. He based this opinion on his understanding of the mechanism of injury and the pathogenesis of disc herniations. PX 34 at 22. He characterized his treatment as reasonable and necessary. He expressed no opinion as to whether Petitioner requires additional low back care. PX 34 at 22. As of January 2013, he believed Petitioner required a decompression and fusion but, currently, he has "no idea" what kind of treatment Petitioner might need. This is because he has not seen Petitioner recently. PX 34 at 23. He believes Petitioner was unable to work from the initial visit to October 2012. PX 34 at 23.

Under cross-examination, Dr. Lim acknowledged he has no idea what Petitioner's current condition is. PX 34 at 24. Petitioner never underwent the decompression and/or fusion. PX 34 at 24. It is Gordon Waddell who, in 1984, suggested there is a significant chance a patient's symptoms are non-physiologically based if three of five signs are positive. PX 34 at 24. If a patient has three out of five positive Waddell's signs, he is a poor candidate for surgery. He did not specifically note positive

Waddell's findings in any note other than his first but it is his practice to document only changes in a person's condition. PX 34 at 25. He does not recall whether Petitioner's initially noted symptom magnification changed over time. PX 34 at 25. After the surgery, Petitioner "improved to a certain point and then deteriorated." On August 26, 2011, he noted that all of Petitioner's pain had returned a month earlier, following some injury. He has no idea what injury Petitioner was referring to. It "seems like" Petitioner deteriorated after this injury. PX 34 at 26. He did not treat Petitioner's knee and has no opinions concerning the knee condition. PX 34 at 26-27. He is not aware of Petitioner having any other health conditions. PX 34 at 27. He does not know whether Petitioner was in fact fired. PX 34 at 27.

On redirect, Dr. Lim testified that the fact Petitioner exhibited two positive Waddell's signs did not automatically mean he was a poor candidate for surgery. He documented symptom magnification when he first saw Petitioner. He does not know whether he continued to believe Petitioner was magnifying his symptoms after he saw the actual MRI film. The MRIs taken in 2011 and 2012 were not markedly different. PX 34 at 28-29.

On December 9, 2015, Dr. Brooker re-examined Petitioner's left knee, noting a mild effusion, no instability and a limited range of motion. He diagnosed degenerative arthritis and administered a Marcaine injection. PX 14.

Dr. Brooker testified by way of evidence deposition on April 18, 2016. Dr. Brooker testified he is board certified in orthopedic surgery. PX 35 at 5. He performs knee surgeries and sees about 400 patients with knee problems per month. PX 35 at 5. As far as he knows, Petitioner's counsel did not arrange for him to treat Petitioner. PX 35 at 7.

Dr. Brooker testified he first saw Petitioner on January 19, 2009. Petitioner told him he injured his left knee and low back a month earlier secondary to a work fall. PX 35 at 8. On initial examination, he noted a positive McMurray test and positive straight leg raising. The positive McMurray test raised concern for a meniscal tear and the positive straight leg raising test was indicative of nerve irritation. PX 35 at 9. He ordered MRI scans of both the lumbar spine and left knee. The left knee MRI showed a meniscal tear but also a "fairly significant amount of arthritic changes." The lumbar spine MRI showed mild nerve impingement. PX 35 at 10.

Dr. Brooker opined that the work accident probably caused Petitioner's meniscal tear but not the arthritic changes in the knee. PX 35 at 10. When he operated on Petitioner's knee, he noted a meniscal tear on the medial side of the knee as well as chondromalacia in various areas. PX 35 at 11. Postoperatively, Petitioner experienced a good deal of pain radiating down his left leg. This caused him to suspect that the source of Petitioner's problem was the back, not the knee. He referred Petitioner to pain management specialist. PX 35 at 12. On June 8, 2009, he started Petitioner on Lyrica but Petitioner had difficulty tolerating that medication. He continued to keep Petitioner off work. There was a delay in Petitioner getting in to see the pain management specialist. On September 8, 2009, he recommended that Petitioner see a spine surgeon. He referred Petitioner to Dr. Lim. PX 35 at 14. Petitioner continued having knee problems while seeing Dr. Lim for his back. PX 35 at 15.

Dr. Brooker testified he next saw Petitioner on May 29, 2015. Petitioner was experiencing bilateral knee pain at that point. He injected both knees and obtained weight bearing X-rays, which showed arthritic changes that were not yet "bone on bone." PX 35 at 15. He referred Petitioner back to Dr. Lim.

Dr. Brooker opined that Petitioner has post-traumatic degenerative arthritis as well as degenerative arthritis of his left knee as well as persistent lumbar radiculopathy and some form of complex regional pain syndrome affecting his left leg. PX 35 at 16. He bases his CRPS diagnosis on the X-rays, the treatment Petitioner underwent for his back and Petitioner's residual leg symptoms. PX 35 at 16. More likely than not, the work accident caused the meniscal tear and aggravated the underlying arthritis. PX 35 at 17.

Dr. Brooker testified that Petitioner's left knee treatment has been reasonable and necessary. Theoretically, it would be possible to perform a left knee replacement but the nerve issue in the left leg "would make an optimal recovery a lot less likely." Therefore, replacement surgery "would have to be done very cautiously, if at all." PX 35 at 17.

Dr. Brooker testified that, with respect to his left knee, Petitioner requires permanent restrictions of no climbing, crouching or kneeling, no lifting over 15 pounds and limited standing and walking, with ten-minute intervals of rest in between standing and walking. PX 35 at 18. Petitioner required these restrictions as of September 8, 2009. PX 35 at 18.

Under cross-examination, Dr. Brooker testified he has no knowledge as to Petitioner's condition prior to January 2009. He was not aware Petitioner previously underwent right knee care. PX 35 at 19. As of the first visit, he had only left knee X-rays to refer to. It was not until significantly later that he took comparative X-rays of both legs. PX 35 at 19. The February 2009 MRI showed changes that were close to "bone on bone" along with a meniscal tear. The tear did not cause the arthritic changes. Without pre-accident imaging, he cannot tell how much degeneration existed before the accident. PX 35 at 20. It would not be unusual for a person in his 50s to have degenerative changes in his knee. PX 35 at 20. He performed a meniscal repair because Petitioner was complaining of sharp mechanical pain in his knee. The meniscal repair was not going to cure the arthritis. PX 35 at 21.

Dr. Brooker testified that, while he was the first to suspect lumbar issues, he did not directly treat Petitioner's back. He did not see Petitioner between September 2009 and May 2015. PX 35 at 21. He did not release Petitioner from care in September 2009. PX 35 at 22. He has some of Dr. Lim's records and knows Petitioner underwent spine surgery. When Petitioner returned in May 2015, he had problems in both knees. The degeneration in Petitioner's right knee is not as extensive as that in his left. PX 35 at 22-23. On X-ray, the left knee looks worse than the right. PX 35 at 23. It is not possible for him to rule out the possibility that Petitioner was very sensitive to pain. That extreme sensitivity is an alternative to the CRPS diagnosis. This is why he sent Petitioner to a pain management specialist. PX 35 at 24. The surgery he performed was relatively minor, with a typical recovery time of one to two months. PX 35 at 24-25. The restrictions he imposed were not based on a functional capacity evaluation. He is not aware of Petitioner having ever undergone such an evaluation. PX 35 at 25. His inclination is to not recommend replacement surgery for Petitioner "unless we know that the extra sensitivity in his leg is under control." Even then, Petitioner would have to understand that the replacement surgery could increase his pain. Petitioner might, in the future, require right knee replacement surgery also. PX 35 at 26.

On May 10, 2016, Petitioner underwent a CT scan of the abdomen and pelvis following testing showing an elevated PSA of 90.15. The radiologist compared the scan with an earlier scan performed on December 8, 2014. He noted "interval development of a rounded peripherally sclerotic lesion within the T10 vertebral body" which he described as "worrisome for a metastatic lesion." PX 10.

Petitioner testified he currently takes Ibuprofen for pain. His wife has to help him get dressed. Walking a short distance helps his knee but extended walking or standing tends to aggravate his knee and back pain. Before the accident, he enjoyed playing golf, fishing, playing basketball with his grandsons and having sex with his wife. He is now unable to engage in those activities. His grandsons are now 10 and 20 years old. One of his grandsons lives with him. That grandson wants to continue to engage in activities with him but sees that he cannot do this.

Under cross-examination, Petitioner acknowledged being treated for prostate cancer before 2008. He has borderline diabetes and some degree of hypertension now but did not have these conditions in 2008. He injured his right knee in 2004 and underwent right knee surgery. This surgery helped his knee feel much better but he still has problems with the right knee. His right knee started giving out after the 2008 work accident. He did not recall injuring his low back in 2005. He did not recall claiming short-term disability due to dizziness before 2008. He would not add any details to the description of the accident he gave on direct examination. He signed and dated RX 1, an accident report, on December 16, 2008, the day after the accident. It was slippery on December 15, 2008. He lost consciousness after falling. When he woke up, paramedics were already there. He cannot recall what position his body was in. He reached for a pole as he got off the bus and then fell. He was provided with crutches after the accident and began using a cane a few days later. Before he began using a cane, he had to lean on furniture while attempting to walk. No doctor prescribed a cane but Drs. Brooker and Lim, as well as his family doctor, said he could use a cane if he needed to. The doctors showed him how to use a cane. He currently takes Ibuprofen 800 and Hydrocodone. He previously took Flexeril but stopped because it upset his stomach. When Dr. Goldberg told him to touch his toes, he looked at the doctor as if he was crazy. He has never attempted to apply for a new position with Respondent or another employer. He never tried to return to work because he knows he could not work.

On redirect, Petitioner described his left knee as worse than his right. He receives Social Security disability benefits. At one Section 12 examination, the examiner wanted him to touch his toes. Each examination lasted about five minutes. His doctors instructed him in proper use of a cane. He believes they told him to hold the cane in his left hand.

Under re-cross, Petitioner testified his doctors told him it was all right to use either of his hands to hold the cane, depending on his comfort level. At the first Section 12 examination, he asked the doctor to lower his examination table and the doctor said he could not lower it. The following examinations consisted of the doctor looking at him and dictating into a machine. He cannot recall the doctor testing his hip range of motion.

Carl Triebold, a certified vocational rehabilitation counselor, testified on behalf of Petitioner. Triebold testified he was retained and paid by Petitioner's counsel. He interviewed Petitioner on June 27, 2016 and issued a report on July 15, 2016 (PX 36). In connection with his evaluation, he reviewed the functional capacity evaluation, records from Drs. Lim and Brooker and Dr. Goldberg's reports. Dr. Lim believed Petitioner was capable of light duty with restrictions relative to lifting, standing/walking and the duration of the workday. As of January 2016, Dr. Brooker believed Petitioner required restrictions relative to walking and lifting. Dr. Goldberg believed Petitioner could not resume driving but could resume full duty.

Triebold described Petitioner's bus driver job as semi-skilled and falling into the medium physical demand level. In his opinion, Petitioner had no transferable skills other than his bus driving skills. Petitioner attended some college but did not obtain a degree.

Triebold testified that, if he were to follow the treating physicians' restrictions and also consider Petitioner's lack of transferable skills, Petitioner would not be capable of returning to work. If, on the other hand, he adopted Dr. Goldberg's assessment, Petitioner could earn between $8.25 and $12.00 per hour.

Under cross-examination, Triebold testified he billed $773 for his evaluation, travel time and report. He is not a medical doctor. He never reviewed a formal functional capacity evaluation. Such an evaluation could address effort and determine more specific limitations. It would have been helpful to have a functional capacity evaluation in this case. He did not review Dr. Goldberg's initial report. He interprets Dr. Goldberg's statement in his 2011 report, i.e., "I cannot imagine Petitioner being able to walk to work or drive" literally. He realizes the doctor went on to state that Petitioner can work, at least from an objective anatomic viewpoint. To a vocational counselor, it does not matter whether a restriction stems from an anatomic abnormality. He is aware that, in 2015, Dr. Goldberg opined Petitioner could work full duty from an anatomic standpoint but for pain resulting from his non-work-related prostate cancer. The underlying cause of Petitioner's limitations is not something he considered. He did not perform a labor market survey. He is not aware of any job search. He believes vocational rehabilitation is not warranted in Petitioner's case. His report refers to Petitioner being able to perform limited standing but Dr. Lim said Petitioner could stand and walk frequently. He did not review any Respondent job descriptions.

On redirect, Triebold testified his pay is not contingent on his opinions. He believes Petitioner would not find work if he looked, based on his restrictions and age.

Arbitrator's Credibility Assessment

Petitioner was less than credible as to his pre-accident state of health. As of the accident, Petitioner was being followed for prostate cancer, after undergoing surgery in 2004, along with other health conditions.

Petitioner testified he experienced pain in his back as well as his left leg after the accident. His initial Emergency Room records do not mention the back but a history recorded only two days after the accident reflects Petitioner twisted both his back and his knee. Petitioner testified he initially focused on his leg. That is logical, since, with respect to his back injury, his symptoms were largely radicular.

While the various accounts of the accident are not entirely consistent, the Arbitrator concludes Petitioner injured his back as well as his knee, with that injury leading to the need for the microdiscectomy of February 2011. See further below in the section relating to causation.

As for the doctors' evaluations of Petitioner's credibility, Dr. Brooker diagnosed complex regional pain syndrome but conceded Petitioner might alternatively be simply very sensitive to pain. Dr. Gandhi, the pain physician who saw Petitioner at Dr. Brooker's referral, did not diagnose complex regional pain syndrome. He noted he was unable to test Petitioner's strength due to severe guarding. Dr. Lim noted 2/2 positive Waddell's signs but testified this did not mean Petitioner was a poor surgical candidate. Respondent's examiner, Dr. Goldberg, noted symptom magnification but conceded the need

for the left knee surgery. He also conceded there was a 25% chance that back surgery would be beneficial. At his deposition, Dr. Goldberg acknowledged Petitioner was not able to work but attributed that inability to Petitioner's prostate cancer.

Arbitrator's Conclusions of Law

Did Petitioner establish causation as to his various claimed conditions of ill-being?

Initially, the Arbitrator finds that Petitioner established causation as to a left knee condition that required arthroscopic surgery, including a meniscal repair, as well as follow-up care in 2015, and that remains symptomatic. The Arbitrator further finds that the accident contributed to the worsening of Petitioner's left knee over time, to the point where Dr. Brooker believes he would benefit from a left knee replacement but for his overall pain level. In so finding, the Arbitrator relies on the following: 1) Petitioner's testimony that he felt left knee pain shortly after the accident; 2) the Emergency Room records, which document a left knee injury; 3) the left knee MRIs; 4) Dr. Brooker's operative findings; 5) the causation opinions expressed by Dr. Brooker; 6) Dr. Goldberg's concession that the accident likely resulted in the need for left knee surgery; and 7) the fact that, while Petitioner has degenerative changes in both knees, his left knee degeneration is more advanced.

The Arbitrator further finds that Petitioner established causation as to a low back and left-sided radicular condition that required a course of conservative care, including epidural injections, and ultimately a microdiscectomy in 2011. In so finding, the Arbitrator relies on the following: 1) Petitioner's testimony that he experienced low back as well as left knee pain after the accident; 2) the Concentra records of December 17, 2008, which describe a twisting injury to both the back and the left knee; 3) the December 2008 records of Petitioner's primary care physician, which mention the back as well as the left leg; 4) Dr. Lim's opinions; 5) the lumbar spine MRIs, which showed left-sided, correlative pathology; and 6) Dr. Goldberg's concessions that the epidural injections were reasonable and there was a chance back surgery might result in improvement.

In addressing causation as to the back, the Arbitrator acknowledges Petitioner reported some kind of intervening accident to Dr. Lim several months after the February 2011 microdiscectomy. The Arbitrator notes, however, that the repeat radiographic studies performed thereafter did not show any new disc pathology.

While the Arbitrator believes that the left knee and low back conditions required treatment and resulted in some degree of disability, the Arbitrator does not find causation as to complex regional pain syndrome or the severe chronic pain/weakness which Petitioner points to as the cause of his claimed inability to work. Of the three surgeons who evaluated Petitioner and commented on work capacity, only Respondent's examiner, Dr. Goldberg, expressed awareness of Petitioner's underlying prostate cancer. The 2014 lumbar spine MRI prompted Dr. Goldberg to suspect metastatic disease. A CT scan, performed in May 2016, well after Dr. Goldberg's deposition, showed interval development of a lesion consistent with metastatic disease. Dr. Brooker recommended very stringent, retroactive work restrictions. He linked the need for these restrictions to the work accident and stated the restrictions would have been appropriate from 2009 forward but the foundation for those opinions is lacking. There was a significant gap in the doctor's treatment and, as stated earlier, the doctor was apparently unaware of Petitioner's cancer diagnosis and metastatic disease. Moreover, the doctor did not base his recommendations on any functional capacity evaluation.

The Arbitrator also finds that Petitioner did not establish causation as to his current right knee condition of ill-being. There is no evidence indicating Petitioner injured his right knee in the original accident. Dr. Brooker did not render any opinion linking Petitioner's right knee condition to the accident or the left knee condition.

Is Petitioner entitled to temporary total disability benefits from September 3, 2009 through the hearing of July 22, 2016?

Respondent does not dispute that Petitioner was temporarily totally disabled from December 16, 2008 through September 2, 2009. The parties agree that Respondent paid $222,252.82 in temporary total disability benefits. Arb Exh 1.

The Arbitrator has previously found that Petitioner established causation as to left knee and low back conditions that required surgery. The Arbitrator has also found that these conditions resulted in a degree of permanent disability. The Arbitrator views Petitioner's conditions as stabilizing as of January 11, 2013, the date on which Dr. Lim noted Petitioner declined more back surgery and found Petitioner capable of light duty. Petitioner did resume left (and right) knee treatment with Dr. Brooker in 2015 but this treatment was palliative in nature. It appears Dr. Brooker has significant reservations about performing additional left knee surgery.

The Arbitrator finds that Petitioner was temporarily totally disabled from December 16, 2008 through September 2, 2009, based on Respondent's stipulation, and from September 3, 2009 through January 11, 2013, with Respondent receiving credit for the $222,252.82 in benefits it paid prior to trial. The two intervals of disability are equivalent to 212 3/7 weeks.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims a number of unpaid medical bills. PX 33. The Arbitrator addresses these bills below:

	CLAIMED
1. Advocate Medical Group Dr. Manaparambil, various office visits, 12/08 – 4/16	$4,384.53
The Arbitrator awards the $245.00 in expenses associated with the post-accident visit of December 22, 2008 and the $210.00 in charges associated with the pre-operative evaluation of January 20, 2011. The Arbitrator declines to award the remaining claimed charges as they relate to evaluation of a variety of general health conditions.	
2. PTSIR, therapy 1/19/10 – 10/26/11	$6,325.00
The Arbitrator, having found that Petitioner established causation as to a back condition that ultimately required a microdiscectomy in February 2011, awards the claimed charges.	
3. Advocate Christ Hospital, 2/17/11 (microdisecetomy)	$23,629.00

The Arbitrator, having found that Petitioner established causation as to a back condition that ultimately required a microdiscectomy, awards the claimed charges.

4. Midland Orthopedics (Dr. Brooker), office visits and surgery $ 1,410.83

The Arbitrator has previously found that Petitioner established causation as to a left knee condition that required surgery. The Arbitrator has also found that Petitioner failed to establish causation as to his right knee condition. Of the claimed $1,410.83, the Arbitrator awards $586.21. The Arbitrator declines to award the remaining $814.62 as those charges relate to right knee injections performed in June and September 2015.

5. High Tech (various MRI and CT scans, 10/10 – 5/16) $ 7,182.00

The Arbitrator, having found that Petitioner established causation as to back and knee conditions that required surgery, awards the lumbar spine MRI charges of $950.00, $1,610.00 $1,610.00 and $1,587.00 and the left knee MRI charges of $950.00. The Arbitrator declines to award any of the other charges listed on the High Tech bill since they relate to imaging of other body parts secondary to Petitioner's prostate cancer.

6. Midwest Orthopaedic Consultants, S.C. (Dr. Lim) $1,342.00

The Arbitrator declines to award Petitioner the claimed $1,342.00 as the May 2, 2016 bill in PX 33 shows a $0 balance. It appears to the Arbitrator that Dr. Lim's charges between June 24, 2011 and January 11, 2013 were paid by Advocate. The parties reached an 8(j) stipulation and Respondent is to hold Petitioner harmless.

7. St. Margaret Mercy Healthcare, ER visit, 9/15/09 $ 559.26

The Arbitrator, having found causation as to back and left knee conditions, awards the claimed Emergency Room charges as the corresponding records reference the work accident and show Petitioner sought treatment for back and left leg pain.

8. Neurologic Associates (Dr. Itkin), EMG, 8/17/11 $ 900.00

The Arbitrator, having found causation as to Petitioner's back condition and surgery, awards the claimed charges as

they relate to an EMG performed to evaluate Petitioner's post-operative back complaints. The Arbitrator finds it reasonable for Dr. Lim to have ordered EMG testing based on those complaints.

9. Dr. Harsoor, balance for multiple visits/medications, 2014-2015 $ 200.00

The Arbitrator declines to award the claimed balance, based on the foregoing finding that Petitioner's condition stabilized as of January 11, 2013. Dr. Harsoor treated Petitioner after that date.

What is the nature and extent of the injury?

This is a pre-amendatory case, since the undisputed accident occurred prior to September 1, 2011.

The Arbitrator has previously found that Petitioner established causation as to two conditions: 1) a left knee condition that required an arthroscopy and that remains symptomatic; and 2) a low back condition with radicular symptoms that ultimately required a microdiscectomy. The Arbitrator has also found that these conditions resulted in some degree of permanent disability but does not believe these conditions led to the need for the stringent restrictions imposed by Dr. Brooker. As stated earlier, there was a lengthy gap in Dr. Brooker's care and the doctor never expressed any awareness of Petitioner's cancer. Moreover, the restrictions are not based on any functional capacity evaluation. Dr. Lim did not support the idea of Petitioner claiming total disability. He viewed Petitioner as capable of working. The Arbitrator had some problems with Dr. Goldberg, in that he is not a knee or back specialist, did not review the MRI images and tended to repeat himself in each of his reports, but assigns weight to his opinion that Petitioner has metastatic disease and is currently unable to work for reasons other than the accident.

The Arbitrator, having considered all of the foregoing, declines to award either wage differential or permanent total disability benefits. The Arbitrator awards permanency equivalent to 35% loss of use of the left leg under Section 8(e), equivalent to 75.25 weeks of benefits, as well as 25% loss of use of the person as a whole under Section 8(d)2, equivalent to 125 weeks of 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

KEVIN GROELLER,

Petitioner,

vs.

NO: 10 WC 3612
10 WC 26356

PACKERS SANITATION SERVICES,

Respondent.

18IWCC0390

DECISION AND OPINION ON REVIEW

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

On January 6, 2010 Petitioner was employed by Respondent, Packers Sanitation Services, as a sanitation worker. The parties stipulated that on January 6, 2010 Petitioner sustained accidental injuries that resulted in bilateral L5-S1 lateral recess and foraminal stenosis at L4-5 and right sided herniated lumbar disc. Dr. Slack performed surgery on October 1, 2010. Petitioner subsequently underwent a prolonged course of treatment that included physical therapy, transforaminal epidural steroid injections, and pain medications for a diagnosis of post-lumbar laminectomy syndrome. Petitioner was prescribed narcotic pain medications. On February 22, 2013 Dr. Alzoobi, Petitioner's pain management physician, terminated the physician-patient relationship when Petitioner's drug test came back positive for heroin and cocaine.

The arbitrator denied Petitioner's medical expenses after February 22, 2013 finding that the medical expenses incurred after that date were not reasonable and necessary. The

Commission finds that temporary total disability benefits paid to Petitioner after February 22, 2013 should similarly be terminated.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $245.33 per week (statutory minimum rate for one dependent for a date of accident of January 6, 2010) for a period of 147 5/7 weeks commencing January 13, 2010 through March 24, 2010 (10 weeks) and commencing July 4, 2010 through February 22, 2013, (137 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 $245.33 per week (statutory minimum PPD rate for one dependent for the date of accident January 6, 2010) for a period of 125 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of 25% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical services pursuant to §8(a), 8.2 of the Act, the medical fee schedule and the holding in Springfield Urban League, 2013 IL App (4th) 120219WC for the following medical treatment: Dr. Slack of Illinois Bone & Joint for surgery on October 1, 2010 and other treatment; St. Joseph Hospital for surgery on October 1, 2010 and epidural steroid injection on February 7, 2012; Drs. Watson, Singh and Alzoobi of Health Benefits Pain Management Services for services from February 23, 2010 through February 22, 2013; IL Pharmacy Management for medication from April 21, 2010 through November 3, 2010; IWP for medication from December 2010 to September 2012; Jackson Park Hospital for epidural steroid injections on March 8, 2010, March 22, 2010 and April 5, 2010; Streeterville Open MRI for MRI on August 3, 2010; MRI River North for MRI on January 16, 2012; United Rehab Providers for physical therapy from January 16, 2012; MedSource for HCPCS L0631 on November 19, 2012; Lincoln Park Anesthesia, anesthesia for surgery on October 1, 2010; and Total Rehab and Care Rehab. The Respondent shall receive credit against these bills for any payments made as documented in the Respondent's Payment History Report.

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.

18IWCC0390

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $60,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

JUN 18 2018

DATED:
o-04/19/2018
SJM/msb
44

Stephen J. Mathis

Deborah L. Simpson

DISSENT

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

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GROELLER, KEVIN E
Employee/Petitioner

Case# **10WC003612**

10WC026356

PACKERS SANITATION SERVICES INC
Employer/Respondent

18IWCC0390

On 7/28/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0147 CULLEN HASKINS NICHOLSON ET AL
DAVID B MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0507 RUSIN & MACIOROWSKI LTD
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CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK

18IWCC0390

☐ 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

KEVIN E. GROELLER
Employee/Petitioner

v.

PACKERS SANITATION SERVICES, INC.
Employer/Respondent

Case # **10** WC **3612**

Consolidated cases: **10 WC 26356**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **APRIL 19, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **JANUARY 6, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$17,680.00**; the average weekly wage was **$340.00**.

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

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

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

Respondent shall be given a credit of **$2,266.70** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$2,266.70**.

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

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law*:

1) The Respondent shall pay to the Petitioner temporary total disability benefits of $245.33 per week (statutory minimum TTD rate for 1 dependent for the date of accident January 6, 2010) for 195 6/7 weeks, commencing January 13, 2010 through March 24, 2010 (10 weeks) and commencing July 4, 2010 through January 29, 2014 (185 6/7 weeks) for a total of 195 6/7 weeks of temporary total disability benefits as provided in Section 8(b) of the Act. The Respondent shall be given a credit of $2,266.70 for previously paid TTD benefits.

2) The Respondent shall pay to the Petitioner reasonable and necessary medical services pursuant to Section 8(a), Section 8.2, the medical fee schedule and the holding in Springfield Urban League, 2013 Il App (4th) 120219WC for the following medical treatment: Dr. Slack of Illinois Bone & Joint for surgery on October 1, 2010 and other treatment; St. Joseph Hospital for surgery on October 1, 2010 and epidural steroid injection on February 7, 2012; Drs. Watson, Singh and Alzoobi of Health Benefits Pain Management Services for services from February 23, 2010 through February 22, 2013; IL Pharmacy Management for medication from April 21, 2010 through November 3, 2010; IWP for medication from December 2010 to September 2012; Jackson Park Hospital for epidural steroid injections on March 8, 2010, March 22, 2010 and April 5, 2010; Streeterville Open MRI for MRI on August 3, 2010; MRI River North for MRI on January 16, 2012; United Rehab Providers for physical therapy from January 16, 2012; MedSource for HCPCS L0631 on November 19, 2012; Lincoln Park Anesthesia, anesthesia for surgery on October 1, 2010; and Total Rehab and Care Rehab. The Respondent shall receive credit against these bills for any payments made as documented in the Respondent's Payment History Report. (*RX* 1).

3) The Respondent shall pay to the Petitioner permanent partial disability benefits of $245.33 per week (statutory minimum PPD rate for 1 dependent for the date of accident January 6, 2010) for 125 weeks because the injuries sustained caused 25% loss of person-as-a-whole under Section 8(d)2 of the Act.

4) The Respondent shall pay the Petitioner compensation that has accrued from January 30, 2014 through April 28, 2016, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

JULY 27, 2017
Date

JUL 28 2017

KEVIN E. GROELLER v. PACKERS SANITATION SERVICES, INC.

10 WC 3612

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on April 19, 2016. This claim was consolidated with Application 10 WC 26356. (*Transcript* at 4). The disputed issues for Application 10 WC 3612 are causal connection, medical bills, TTD, and the nature and extent of the alleged injury. (*Arbitrator's Group Exhibit* 1). The disputed issues for Application 10 WC 26356 are accident, notice, causal connection, medical bills, TTD, and the nature and extent of the alleged injury. (*Arbitrator's Group Exhibit* (hereinafter, *AGX*) 1). The parties requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act and agreed to receipt of the Arbitration Decision via e-mail. (*AGX* 1).

FINDINGS OF FACT

On January 6, 2010, the Petitioner was employed by the Respondent Packers Sanitation Services, as a sanitation worker, which job required the Petitioner to lift, walk and crawl. The job of sanitation worker is classified in the heavy category. (See *Petitioner's Exhibit* 7 at 4 and *Petitioner's Exhibit* 8 at 1). Prior to January 6, 2010, the Petitioner was working full duty in his job as a sanitation worker, was not receiving any medical treatment for a back injury, and was not noticing anything unusual about his back or right leg.

The parties stipulated that on January 6, 2010, the Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent. (*AGX* 1). At that time, the Petitioner testified he was bending over, lifting and removing a steel cover from a machine. He reported the cover became stuck and he immediately noticed a shooting pain in his buttocks down to his right foot. The parties also stipulated the Petitioner gave timely notice of that work accident. (*AGX* 1).

The Petitioner sought immediate medical treatment at Holy Cross Hospital on January 6, 2010 and his diagnosis was low back sprain/strain. (*Petitioner's Exhibit* (hereinafter, *PX*) 1 at 13). He followed up at Holy Cross Hospital on January 13, 2010 and clinical impression was low back pain and possible right sciatica. (*PX* 1 at 35). The Petitioner then received physical therapy evaluation at Holy Cross Hospital on February 8, 2010. (*PX* 1 at 46).

On January 8, 2010, at the direction of the Respondent, the Petitioner received medical treatment at MercyWorks on Ashland where his diagnosis was lumbosacral muscle strain and he was placed on restricted work activity. (*PX* 2 at 3). The Petitioner then followed up at MercyWorks on January 12, 2010 and his work restrictions were maintained. (*PX* 2 at 3).

On January 18, 2010, the Petitioner sought medical treatment from Dr. Catherine Kallal, M.D., at Holy Cross Hospital Archer Medical Center. (*PX* 3 at 9). Dr. Kallal noted the Petitioner's injury at work and that he had severe pain in his right thigh. (*PX* 3 at 9 and *Respondent's Exhibit* 9). On January 29, 2010, at the referral of Dr. Kallal, the Petitioner underwent EMG/NCV at Holy Cross Hospital that demonstrated right L5 radiculopathy. (*PX* 3 at 32). On February 4, 2010, at the referral of Dr. Kallal, he underwent an MRI at Preferred Open MRI which showed foraminal stenosis, particularly on the right at L5-S1. (*PX* 3 at 30).

On February 23, 2010, at the request of Dr. Kallal for consultation, the Petitioner was seen by Dr. Artelia Watson, M.D. at Health Benefits Pain Management Services. (*PX* 11 at 46). The Petitioner then underwent three epidural steroid injections for lumbar radiculitis by Dr. Watson at Jackson Park Hospital on: March 8, 2010; March 22, 2010; and April 5, 2010. (*PX* 11 at 43, 40 & 37). On April 21, 2010, due to the Petitioner's continued complaints of back and right leg pain despite the lumbar epidural injection series, Dr. Watson recommended Petitioner to see Dr. Charles Slack, M.D. of Illinois Bone & Joint for orthopedic surgical consultation. (*PX* 11 at 36). He continued to follow up with Dr. Watson for medication management until he underwent surgery in October 2010. (*PX* 11 at 31-35).

On May 14, 2010, the Petitioner saw Dr. Slack who found the Petitioner had persistent right lumbar radiculopathy with foraminal stenosis on the right at L5-S1. (*PX* 4 at 112). Dr. Slack opined the Petitioner might be a candidate for a nerve decompression procedure. (*PX* 4 at 112). On June 10, 2010, the Petitioner was seen by Dr. Charles Mercier M.D. at the request of the Respondent. (*Respondent's Exhibit* (hereinafter, *RX*) 2). Dr. Mercier diagnosed acute lumbosacral strain, placed the Petitioner at maximum medical improvement, and recommended a return to normal job duties. (*RX* 2). On June 21, 2010, the Petitioner reported to Dr. Slack a flare up his radiating right leg pain. (*PX* 4 at 114). Dr. Slack recommended L5 root decompression and disk excision at L5-S1, directed the Petitioner to remain off work, and continued his medication program while awaiting approval for surgery. (*PX* 4 at 115).

On July 2, 2010, the Petitioner returned to work for the Respondent on the over-night shift. Sometime after midnight, on July 3, 2010, the Respondent's on-site manager, Mr. A.J. Plancarte, instructed the Petitioner to suit up in his specialized rubber safety gear. The Petitioner was accompanied out of the presence of Mr. Plancarte to the locker room to suit up by Respondent's safety assistant, Alex. The Petitioner testified he was struggling to put on rubber pants when he noticed a pop in his back and experienced excruciating pain. After that,

he again met with Mr. Plancarte, who then called for an ambulance for Petitioner. The Respondent introduced into evidence a handwritten note that included the date of July 6, 2010. (*RX* 11). The note indicated that when the Petitioner returned to work on July 2, 2010, and while he was waiting for the safety director, the Petitioner coughed. However, there was no foundation both as to the author of the note or the circumstances under which the note was written. (*RX* 11). The note also indicated that Petitioner was to see Dr. Slack on July 8, 2010. (*Id.*).

During that July 8, 2010 appointment with Dr. Slack, the Petitioner reported he felt a pop in his back when he was attempting to put on special pants at work. (*PX* 4 at 116). Dr. Slack reported the Petitioner suffered an exacerbation of right leg pain on July 2, recommended that Petitioner remain temporarily totally disabled from work, and continued to endorse a surgical option for the Petitioner's lumbar surgery. (*RX* 4 at 117 and 121).

Subsequently, on August 3, 2010, an MRI performed at Streeterville Open MRI showed mild central and foraminal stenosis at L4-L5 and moderate to severe right foraminal stenosis at L5-S1. (RX 8). Dr. Slack, on October 1, 2010, performed bilateral L5-S1 hemilaminotomies, medical facetectomies and foraminotomies, with root decompressions, and right sided L4-5 hemilaminotomy, medial facetectomy and excision of herniated nucleus pulposus, all under microscope magnification, at St. Joseph Hospital. (*PX* 5 at 92). Dr. Slack reported a post-operative diagnosis consisting of bilateral L5-S1 lateral recess and foraminal stenosis and L4-L5 right sided herniated lumbar disk. (*PX* 5 at 92).

After the surgery, the Petitioner continued to follow up with Dr. Slack and Dr. Watson in 2011. (*PX* 4 at 76 and *PX* 11 at 30). Dr. Slack recommended the Petitioner undergo physical therapy and medication management with Dr. Watson. (*PX* 4 at 77). On December 7, 2011, Petitioner underwent functional capacity evaluation at United Rehab Providers that showed him capable of functioning in a light strength category. (*PX* 7 at 4). Thereafter, on December 19, 2011, he followed up with Health Benefits Pain Management Services, the same practice as Dr. Watson, and saw Dr. Ranjeet Singh, M.D. (*PX* 11 at 20). Dr. Singh continued Petitioner's medication program while also recommending additional testing, including MRI and EMG studies. (*PX* 11 at 21). The December 27, 2011, EMG test, performed at Electrodiagnostics Lab in Chicago, showed chronic L4-L5 and chronic L5-S1 radiculopathies. (*RX* 8). The January 16, 2012, MRI study at River North MRI showed trace retrolisthesis of L5 on S1 and post-surgical changes within the posterior elements at L5-S1. (*RX* 8). In January 2012, Petitioner participated in additional physical therapy at Uniterd Rehab Providers to increase his strength and functional mobility. (*PX* 12 at 1).

On February 7, 2012, at St. Joseph Hospital in Chicago, Dr. Singh performed a transforaminal epidural steroid injection on the right side at the L4-L5 nerve root. (*RX* 8 and *PX*

5 at 3). Then, on March 14, 2012 at Jackson Park Hospital in Chicago, Dr. Singh performed a transforaminal epidural steroid injection at L4-L5. (*RX* 8). Subsequently, on May 21, 2012, Dr. Singh reported the recent EMG showed right L4-5 chronic radiculopathy, prescribed the Petitioner his usual medications of Norco, gabapentin, naproxen and Flexeril, and opined the Petitioner was at maximum medical improvement from a pain management perspective. (*PX* 11 at 12 and *RX* 8).

Later that year, on August 9, 2012, the Petitioner returned to Health Benefits Pain Management Services, the same practice as Dr. Watson and Dr. Singh, and saw Dr. Anas Alzoobi, M.D. During that visit, Dr. Alzoobi opined the Petitioner was having symptomatic retrolisthesis of the lumbar spine with radiculopathy. (*PX* 11 at 6 and *RX* 8). The Petitioner also told Dr. Alzoobi that he wanted to be weaned off his medication. (*PX* 11 at 6).

On September 5, 2012, Petitioner returned to Dr. Slack, who noted that the Petitioner was having persistent lower radicular symptoms, his status was post-lumbar diskektomy with post-lumbar laminenctomy syndrome, urged the Petitioner to undergo a lumbar discogram, and suggested the Petitioner could be a candidate for decompression and fusion. (*PX* 4 at 34 and *RX* 8).

On September 27, 2012, Dr. Alzoobi continued Petitioner on conservative treatment and medication program, including Norco, Naprosyn and Neurontin, due to the pending discogram study. (*PX* 11 at 4 and *RX* 8). Dr. Azoobi indicated the Petitioner could consider a conservative treatment option of a spinal cord stimulator versus a spinal fusion procedure. (*Id.*). The Petitioner returned to Dr. Alzoobi on November 15, 2012 and February 14, 2012 and was diagnosed as suffering from post-laminectomy failed back syndrome and right lower extremity radiculopathy (*PX* 11 at 3 and *RX* 8) and then with post-laminectomy syndrome with radicular symptoms extending to the lumbar spine and continued medication management, including Norco and Naprosyn. (*PX* 11 at 2 and *RX* 8).

However, on February 22, 2013, Health Benefits Pain Management Services terminated its physician-patient relationship with the Petitioner due to the drug testing performed by Millennium Laboratories on February 18, 2013. (*RX* 8).

On October 14, 2013, Dr. Slack diagnosed the Petitioner as having post lumbar laminectomy syndrome and recommended that Petitioner undergo additional functional capacity evaluation because Petitioner had decided not to undergo additional testing or surgical intervention. (*PX* 4 at 29). On January 29, 2014, Petitioner underwent functional capacity evaluation at United Rehab Providers in Chicago and demonstrated the ability to perform in the medium physical demand level. (*PX* 8 at 1). On February 13, 2014, Dr. Slack reviewed the functional capacity evaluation with Petitioner, noting that it was a valid study with a

consistency of effort of over 90% and indicating that Petitioner had put forth full and consistent effort. (*PX* 12 at 6). Dr. Slack diagnosed the Petitioner with persistent post-laminectomy syndrome. (*Id.*).

Dr. Slack testified by evidence deposition on September 18, 2014. (*PX* 10). Dr. Slack opined that the Petitioner's post-lumbar laminectomy syndrome is causally related to the incident on the job in January 2010. (*PX* 10 at 33). Dr. Slack opined that the Petitioner's medical treatment, including conservative treatment before the surgery, the surgery itself, and the rehabilitation therapy medications and additional testing after the surgery all were reasonable, necessary and causally related to the work injury. (*PX* 10 at 34-36). Dr. Slack opined that the Petitioner has a permanent restriction on his ability to work of 22-pound occasional lifting. (*PX* 10 at 32).

Dr. Mercier, the Respondent's Section 12 examining physician, testified by evidence deposition on January 27, 2015. (*RX* 6). Dr. Mercier opined the Petitioner had sustained acute lumbosacral muscle ligament strain on January 6, 2010. (*RX* 6 at 16 and 58). As of June 10, 2010, Dr. Mercier reported the Petitioner had positive physical findings of numbness and weakness in his right foot and positive straight leg raising in the supine position. (*RX* 6 at 52-54). Dr. Mercier indicated a positive EMG cannot be faked. (*RX* 6 at 59). Dr. Mercier acknowledged the temporary effect of the epidural injections before the surgery could be diagnostic to some extent. (*RX* 6 at 60). Dr. Mercier reviewed no previous diagnostic testing before January 6, 2010. (*RX* 6 at 61). Dr. Mercier opined an acute lumbosacral strain can never aggravate degenerative pathology. (*RX* 6 at 63). Dr. Mercier also indicated that any cough by the Petitioner at work had no impact on Petitioner's condition one way or another. (*RX* 6 at 67).

The Petitioner initially was released to return to work with restrictions by MercyWorks on January 8, 2010. The Respondent stipulated that Petitioner was temporarily totally disabled from January 13, 2010 through March 24, 2010 or 10 weeks. (AG*X* 1). The Petitioner then continued to work for Respondent in light duty status after March 24, 2010, occasionally missing days from work. (*RX* 11). The Petitioner did not work at all for Respondent or for any employer after July 3, 2010. In late 2011, Petitioner attempted to work for a towing company for about two weeks of training but was unable to continue to do so. He has not worked at all since then. The Petitioner testified he continues to notice shooting pain in his back and right leg and foot. He performs stretching and walking exercises when he notices these symptoms.

The Petitioner also admitted to using cocaine and heroin and to being arrested for possession of illegal drugs. He denied ever trading or selling illegal drugs. Furthermore, the Petitioner admitted to being convicted of the felony of retail theft and the felony of robbery. Petitioner acknowledged he received treatment in jail for opiate addiction. The Respondent

introduced into evidence the Petitioner's arrest record from the Chicago Police Department. (*RX* 7).[1]

The Petitioner introduced into evidence various medical bills. (*PX* 9). The bills include: Illinois Bone & Joint for surgery & other treatment (*PX* 9 at 47); St. Joseph Hospital for surgery on October 1, 2010 & epidural steroid injection on February 7, 2012 (*PX* 9 at 36); Health Benefits Pain Management Services for services from February 23, 2010 through February 14, 2013 (*PX* 9 at 72-116); IL Pharmacy Management for medication from April 21, 2010 through November 3, 2010 (*PX* 9 at 117-141); IWP for medication from December 2010 to September 2012 (*PX* 9 at 51-70); Jackson Park Hospital for epidural steroid injections on March 8, 2010, March 22, 2010 and April 5, 2010 (*PX* 9 at 142-146); Streeterville Open MRI for MRI on August 3, 2010 (*PX* 9 at 156); MRI River North for MRI on January 16, 2012 (*PX* 9 at 164); United Rehab Providers for physical therapy from January 16, 2012 (*PX* 9 at 150); MedSource for HCPCS L0631 on November 19, 2012; Lincoln Park Anesthesia, anesthesia for surgery October 1, 2010 (*PX* 9 at 71); and Total Rehab and Care Rehab (*PX* 9).

The Respondent introduced into evidence a Payment History Report. (*RX* 1). The Payment History Report shows that Respondent paid certain medical bills including prescription, physical therapy, hospitalization, physician services, anesthesia, medical testing, hospital outpatient, home health care and durable medical to various medical providers for dates of service from January 13, 2010 through December 7, 2011. (*RX* 1).

CONCLUSIONS OF LAW

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

Issue F: *Causal connection*

The Arbitrator, as to Application 10 WC 3612, concludes the Petitioner's condition of ill-being is causally connected to the accidental injuries of January 6, 2010. The parties stipulated that Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent on January 6, 2012. The Arbitrator relies on the opinion of Dr. Slack and the continuous consistent complaints in the medical records. As early as January 29, 2010, or about 3 weeks after the stipulated accidental injuries, the Petitioner was demonstrating radiculopathy as documented by the EMG. As early as May 14, 2010, Dr. Slack was considering surgery for the Petitioner. The Arbitrator assigns greater weight and credibility

[1] The Arbitrator notes Illinois Rule of Evidence 609 in his consideration of this evidence.

to the opinions of the treating surgeon, Dr. Slack. Even the Respondent's expert Dr. Mercier acknowledged that the Petitioner sustained an acute injury on January 6, 2010. The Arbitrator discounts Dr. Mercier's other opinions because of Dr. Mercier's unequivocal belief that acute injury cannot ever aggravate underlying pathology.

The Arbitrator, as to Application 10 WC 26356, concludes the accidental injuries of July 3, 2010, even if caused by a cough as seemingly alleged by the Respondent, do not constitute an independent intervening event that breaks the causal connection between the accidental injuries of January 6, 2010 and the ensuing disability and medical treatment. The Arbitrator relies on *Vogel v. Il Workers' Compensation Commission*, 354 Ill.App.3d 780 (2005). An upsurge of pain or symptoms does not mean that the causal connection is broken, especially considering prior documented radiculopathy as confirmed by the positive diagnostic testing on EMG and the prior medical treatment, as was the case here. As early as May 14, 2010, Dr. Slack was considering surgery for the Petitioner. Even Dr. Mercier stated that the cough had no impact on the Petitioner's condition one way or another.

Issue J: *Medical bills*

The Arbitrator concludes that all medical treatment up to February 22, 2013 that Petitioner received for his back injury was reasonable, necessary and related to the accidental injuries of January 6, 2010. The Arbitrator bases this conclusion on the conclusion relating to causal connection above and on the opinions of Dr. Slack. The Arbitrator cuts off the reasonableness and necessity of the medical treatment as of February 22, 2013 because Dr. Alzoobi terminated the physician-patient relationship with Petitioner because of a positive drug test. The treatment awarded by the Arbitrator specifically includes the surgery of October 1, 2010. In addition, the Arbitrator awards to the Petitioner all the medical treatment provided to him from January 6, 2010 through February 22, 2013 from the following medical providers:

1. Dr. Slack of Illinois Bone & Joint for surgery & other treatment;
2. St. Joseph Hospital for surgery on October 1, 2010 & epidural steroid injection on February 7, 2012;
3. Drs. Watson, Singh and Alzoobi of Health Benefits Pain Management Services for services from February 23, 2010 through February 22, 2013;
4. IL Pharmacy Management for medication from April 21, 2010 through November 3, 2010;
5. IWP for medication from December 2010 to September 2012;

6. Jackson Park Hospital for epidural steroid injections on March 8, 2010, March 22, 2010 and April 5, 2010;

7. Streeterville Open MRI for MRI on August 3, 2010;

8. MRI River North for MRI on January 16, 2012;

9. United Rehab Providers for physical therapy from January 16, 2012;

10. MedSource for HCPCS L0631 on November 19, 2012;

11. Lincoln Park Anesthesia, anesthesia for surgery October 1, 2010; and

12. Total Rehab and Care Rehab.

The Respondent shall receive credit against these bills for any payments made as documented in the Respondent's Payment History Report. (*RX* 1).

Issue K: *TTD*

The Arbitrator concludes the Petitioner was temporarily and totally disabled from January 13, 2010 through March 24, 2010 (10 weeks) and from July 4, 2010 through January 29, 2014 (185 6/7 weeks) for a total of 195 6/7 weeks of temporary total disability benefits.

The Respondent paid temporary total disability benefits for the first period from January 13, 2010 through March 24, 2010. The Respondent is entitled to credit for $2,266.70 for the temporary total disability benefits it paid for this period.

For the second period of temporary total disability, the first date, July 4, 2010, is the date after which the Petitioner attempted to return to work full duty for the Respondent. On July 8, 2010, Dr. Slack temporarily and totally disabled the Petitioner. On October 1, 2010, Petitioner underwent surgery. The last date of the second period of temporary total disability, January 29, 2014, is the date of the functional capacity evaluation that released the Petitioner to return to work under medium duty, the date on which the Arbitrator concludes that he reached maximum medical improvement. The Petitioner progressed from light work in the functional capacity evaluation of December 7, 2011 to medium work in the functional capacity evaluation of January 29, 2014.

18IWCC0390

Issue L: *Nature and extent of the injury*[2]

The Arbitrator concludes the Petitioner has sustained accidental injuries causing 25% loss of use of the person-as-a-whole pursuant to Section 8(d)2 of the Act. The Arbitrator bases this conclusion on Dr. Slack's diagnosis of lumbar post-laminectomy syndrome and on the medical records of Health Benefits Pain Management Services. The Petitioner complains of pain in his back and right leg and foot. He has been restricted to medium level work by the functional capacity evaluation of January 29, 2014, partially incapacitating him from pursuing the duties of his usual and customary line of employment involving heavy work as a sanitation worker with the Respondent.

The Arbitrator, in reaching this decision regarding the nature and extent of the Petitioner's injury, as well as **Issues F, J, and K**, above, also has considered the Petitioner's past behaviors documented in *Respondent's Exhibit* 7 and those others admitted to in his trial testimony. The Petitioner's criminal activities and illegal drug use are troubling but, in the Arbitrator's opinion, they do not sufficiently injure his credibility to the point where his testimony would be excluded from consideration.

Signature of Arbitrator

JULY 27, 2017
Date

[2] As Petitioner's accident dates (1/6/10 & 7/3/10) precede the June 28, 2011 effective date of 820 ILCS 305/8.1b, this Arbitration Decision ***will not*** utilize the factors set forth in Section 8.1b in determining the nature and extent of the Petitioner's injury.

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

Angela D. West,

18IWCC0391

Petitioner,

vs. No. 12 WC 06255

Ford Motor Company,

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 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.

The Commission agrees with the Arbitrator's Decision in all respects, except the nature and extent of Petitioner's disability. Regarding Petitioner's right shoulder condition, the only condition of ill-being causally connected to the work accident on March 24, 2011, the Commission notes that Petitioner claims a repetitive trauma injury due to forcefully maneuvering a misaligned assembly line machine for over two weeks. The medical records show that on October 9, 2012, Dr. Ham performed a right shoulder arthroscopic SLAP lesion repair, Bankart lesion repair and subacromial decompression. Postoperatively, Dr. Ham mainly noted stiffness and limited range of motion in the shoulder. On March 6, 2013, Petitioner reported to Dr. Ham she was doing better and the shoulder motion was improving, although she still had residual stiffness. Dr. Ham recommended continuing physical therapy and modified Petitioner's restrictions to no lifting over 25 pounds. In April through August of 2013, Dr. Ham noted progressive improvement in the shoulder condition. On August 30, 2013, Dr. Ham noted: "[The patient] is still having some issues with the shoulder, but has improved." Physical examination

findings were as follows: "[She] has some mild discomfort to terminal motion, which is almost normal at this point. Neurovascular examination is intact. AC joint is nontender. Strength is intact as well throughout." Dr. Ham thought Petitioner was near maximum medical improvement and released her to return to work without restrictions for the shoulder. On October 2, 2013, Petitioner reported the shoulder was doing well. Physical examination findings were as follows: "Shoulder has full stable motion. Strength is good as well." Dr. Ham assessed Petitioner as "doing very well" and at maximum medical improvement with respect to the shoulder condition.

On January 17, 2014, Petitioner returned to Dr. Ham, complaining of "right shoulder pain that is increasing. Pain radiates from the shoulder to the wrist." Physical examination findings were as follows: "[S]he is tender about the AC joint on palpation. Otherwise, she has pretty stable range of motion noted without much discomfort." Dr. Ham ordered an MRI. On February 17, 2014, Petitioner complained of pain over the AC joint, as well as "numbness and tingling." On physical examination, the right shoulder was tender about the AC joint with a positive impingement sign. Dr. Ham noted the MRI of the right shoulder was "not conclusive ***. There are some changes around the site where she was repaired. No definite rotator cuff tear." Dr. Ham ordered electrodiagnostic studies, which proved to be normal. On March 10, 2014, Petitioner complained of pain about the shoulder. On physical examination, the right shoulder was still tender about the AC joint, but not as much. Dr. Ham diagnosed AC joint arthrosis with painful biceps complex, but did not impose any restrictions relative to the right shoulder. On April 2, 2014, Petitioner did not complain of any symptoms about the AC joint. On physical examination, the AC joint was nontender. Rather, Petitioner complained of tenderness along the scapulothoracic area. On April 30, 2014, Petitioner complained of pain in the left shoulder, rather than the right shoulder. Dr. Ham diagnosed "[s]houlder bursitis related to repetitive activity of assembly work" and recommended "a permanent restriction of both shoulders from repetitive activity." On May 14, 2014, physical examination findings were as follows: "[S]he is freely moving her shoulder without much discomfort. Neurovascular examination is intact." Dr. Ham assessed "[i]mproved shoulder pain following stoppage of her assembly work" and instructed Petitioner to follow up as needed.

Thereafter, Petitioner mainly treated with Dr. Salberg, a neurologist, for various complaints. Dr. Salberg ordered a repeat MRI of the right shoulder, among other things. The MRI, performed November 25, 2014, showed postsurgical changes and a small amount of fluid within the subacromial/subdeltoid bursa. Repeat electrodiagnostic studies were normal.

On April 25, 2016, Petitioner returned to Dr. Ham, who noted: "The patient has residual issues of discomfort with repetitive overuse. She works in an assembly line. She noted improvement after surgery but still experiences it with repetitive motion that occurs in the office. *** She has not been working since May 2014, about two years. It is unlikely she will be able to return back to work that she used to do." Physical examination findings were as follows: "Bilateral shoulders have full stable motion. The AC joint is nontender. Negative belly test. O'Brien's test is negative. Shoulders are stable. Mild impingement bilaterally." Dr. Ham

recommended a functional capacity evaluation (FCE). On May 6, 2016, Petitioner reported the insurance would not pay for the FCE. Dr. Ham assessed: "Repetitive work is causing bilateral shoulder pain for which she is disabled."

On April 3, 2017, Petitioner followed up with Dr. Ham, reporting pain with repetitive use, but little pain with rest. Physical examination findings were as follows: "Examination of the right shoulder reveals mild impingement. She has full range of motion, stable. O'Brien's test is negative. Bear hug is negative." Dr. Ham diagnosed mild rotator cuff tendinopathy and prescribed Mobic. On April 26, 2017, Petitioner followed up, at which time Dr. Ham noted "minimal impingement bilaterally" on physical examination. The rest of the examination was normal. Dr. Ham instructed Petitioner to follow up as needed.

Dr. Neal, an orthopedic surgeon who examined Petitioner at Respondent's request in 2013 and 2015, did not find Petitioner's complaints credible. On physical examination, Dr. Neal noted non-physiologic, non-anatomic and non-organic signs. Dr. Neal believed the need for the shoulder surgery performed by Dr. Ham was "principally for the impingement." Dr. Neal did not think Petitioner required restrictions relative to the right shoulder and opined the permanent restrictions imposed by Dr. Ham were unrelated to the work accident.

Dr. Weber, an orthopedic surgeon who examined Petitioner at Respondent's request in January of 2017, noted complaints of pain in the right shoulder mainly with motion and strength testing, as well as decreased range of motion with some voluntary guarding. Dr. Weber diagnosed right shoulder pain of unknown etiology, stating: "[The claimant] complains of significant right shoulder dysfunction. However, she was noted to have full rotator cuff strength, no compensatory movements. She had inconsistent impingement findings. Her subjective complaints did not appear to be supported by any objective findings." Dr. Weber noted the operative report of a Bankart lesion suggested a prior dislocation. Dr. Weber also questioned whether the labral tear was causally connected to the accident. Dr. Weber opined Petitioner's nonspecific right shoulder pain was not causally connected to the accident. Correspondingly, Dr. Weber opined Petitioner required no restrictions relative to the right shoulder.

During the arbitration hearing, Petitioner testified that she was taking Mobic for the right shoulder pain as needed. When Petitioner wakes up in the morning, her right shoulder is painful. The pain is worse with lifting. Petitioner has good and bad days. Petitioner regularly goes to the gym to walk on a treadmill and exercise with three-pound weights. Petitioner stated that exercising is painful, but she does it to keep her muscles active. Petitioner uses a special pillow, called My Pillow, for people with neck problems.

The Commission agrees with the Arbitrator that Petitioner is not credible. The Commission further agrees with the Arbitrator that greater weight must be given to the opinions of Dr. Neal and Dr. Weber, both of whom questioned the veracity of Petitioner's complaints and opined that Petitioner did not require any restrictions relative to the right shoulder. Dr. Neal and Dr. Weber also opined that much pathology in the right shoulder was preexisting. The Arbitrator

found only the right shoulder impingement to be causally connected to the work accident. Having carefully considered the entire record and weighed the evidence, the Commission finds the proper measure of disability is 17.5 percent of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 5, 2017, is hereby 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 $439.23 per week for a period of 10 weeks, from October 9, 2012 through November 7, 2012 and from July 22, 2013 through August 30, 2013, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills from ATI and Bone & Joint Specialists for treatment of the right shoulder impingement syndrome through October 2, 2013, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $395.30 per week for a period of 87.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability to the extent of 17.5 percent of the person as a whole.

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

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

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 18 2018
o-05/24/2018
MJB/sk
44

Michael J. Brennan

David L. Gore

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEST, ANGELA D
Employee/Petitioner

Case# **12WC006255**
12WC006256

FORD MOTOR COMPANY
Employer/Respondent

18IWCC0391

On 9/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
JASON P CARROLL
77 W WASHINTON ST 20TH FL
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
DANIEL A BRAINARD
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

18IWCC0391

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

Angela D. West
Employee/Petitioner
v.
Ford Motor Company
Employer/Respondent

Case # 12 WC 006255

Consolidated with 12 WC 006256

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **June 9, 2011.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. [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 24, 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 to his **right shoulder is, in part,** causally related to the accident.

In the year preceding the injury, Petitioner earned **$34,259.68**; the average weekly wage was **$658.84.**

On the date of accident, Petitioner was **47** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $ of **$2,322.75** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for PPD advances, as identified in Respondent's Exhibit #4, for total credit of **$2,322.75.**

Respondent is entitled to a credit for any amounts paid in medical bills through its group medical plan pursuant to Section 8(j) of the Act.

ORDER

The Arbitrator finds the Petitioner's **right shoulder condition** consisting of a right shoulder impingement was causally related to the work accident of March 24, 2011.

Petitioner shall pay Petitioner temporary total disability benefits of **$439.23** per week, from October 9, 2012 through November 7, 2012 and from July 22, 2013 though and including August 30, 2013 representing **10 weeks**, as provided pursuant to Section 8(b) of the Act. Respondent shall be given a credit of $2,322.75 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services to ATI and Bone and Joint Specialists for treatment to Petitioner's right shoulder impingement syndrome including the pre-surgery physical therapy, right shoulder subacrominal injections, right shoulder arthroscopic surgery and right shoulder post-surgery physical therapy through October 2, 2013 as provided in Sections 8(a) and 8.2 of the Act and subject to the medical fee schedule. Respondent is not liable for medical bills to Northern Indiana Neurological Institute or for treatment Petitioner received for her cervical spine, lumbar spine, left shoulder, arm, hip, carpal tunnel, head, thoracic spine and right shoulder treatment provided after October 2, 2013.

Petitioner failed to prove by the preponderance of the evidence that she is entitled to benefits pursuant to Section 8(d)(1) of the Act.

Respondent shall pay the Petitioner the sum of **$395.30 per week** for a further period of **150 weeks** as provided under **Section 8(d)(2)** of the Act because the injuries sustained caused permanent partial disability to the extent of **30%** loss of use of **man as a whole** as provided under the Act.

Respondent shall pay Petitioner compensation that has accrued from March 24, 2011 through June 9, 2017, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

8/30/17
Date

SEP - 5 2017

INTRODUCTION

On February 21,2012, Petitioner, Angela D. West, filed a claim with the Illinois Workers' Compensation Commission (12WC226255), with a date of accident of 3/24/2012. The Application For Adjustment of Claim lists the body part as "R shoulder and body". Regarding how the accident occurred, the Application For Adjustment of Claim states "at work". The issues in dispute are accident, causal connection, liability for medical expenses, TTD benefits and nature and extend of the injury. (Arb. Ex #1) Petitioner filed an additional claim with a date of accident of 4/1/11 (12WC006256). The Application For Adjustment of Claim lists the body part as "R knee". Regarding how the accident occurred, Petition Application for Adjustment of Claim states "Injured at work. Tripped and fell on ergonomic mat". The issues in dispute are accident, causal connection and nature and extend of the injury. (Arb. Ex. #2) For both cases, the Parties stipulated to employee and employer relationship, notice, and average weekly wage of $658.84. (Arb. Ex.# 1 and 2) The cases were consolidated and a hearing was held on June 9, 2017.

FINDINGS OF FACT

Petitioner, Angela West, testified she began working for Respondent, Ford Motor Company, in September of 2010. (T 17). Petitioner began working as a floater performing various jobs and tasks. (T 17, 50) In January of 2011, Petitioner began to work in a permanent positon on the ignition panel line or IP line. (T. 50) At trial she described her job duties on the IP line as placing brackets into position and snapping them into place, guiding the ignition panel with her right hand and securing the ignition panel in the vehicle using an electric screw gun. (T20-22) The ignition panel was held by a machine which placed the ignition panel into the vehicle. Petitioner testified the machine did most of the work and would guide the ignition panel into proper positon so it could be secured in the vehicle. Petitioner testified "*from time to time the machine would become unaligned...when the machine is unaligned, I would have to physically lift the machine up with the ignition panel and thrust with force to get it to lock into place so that I could bolt it down.*" (T22) Petitioner testified when the machine was not aligned up properly, she would have to lift the ignition panel up 3 to 4 inches so the panel could be bolted to the vehicle. Petitioner testified that although the ignition panel weighted over 100 pound she wasn't lifting the full weight of the panel because panel was being held up by the machine. (T23)

Petitioner testified she worked 40 hours a week and she would start work from 6:00 a.m. to 4:00 p.m. Petitioner testified she would install ignition panels on approximately 600-800 vehicles per day. (T24) On cross examination, Petitioner acknowledged her estimated could be wrong because she was relying on a billboard and she testified that she could be reading the billboard wrong. (T56) Petitioner did not proffer any testimony regarding how often the machine holding the ignition panel would be out of alignment requiring her to lift the machine and push it into alignment.

Petitioner testified that after two weeks of lifting the machine when it was unaligned she started to feel some tension or aching muscles in her right shoulder and neck. (T25) Petitioner testified on March 24, 2011, while performing her daily work she noticed that her right shoulder and neck was "racked" with pain. (T25) Petitioner went to the Ford Motor Company's Occupational Health clinic or "plant medical" for medical attention. (T26) Petitioner was examined by Dr. Khin. While at the company clinic, Petitioner described her job duties that transports ignition panels with a hoist to inside the car and she bolts it down using a gun. Petitioner said she had been experiencing right shoulder pain for two weeks but the pain was worse today. (PX1, p. 6) Dr. Khin observed tenderness at the right base of the neck to the right trapezius. Petitioner's abduction was 90 degrees with minimal internal rotation. Dr. Khin assessed Petitioner with a sprain/strain of the right shoulder, upper arm and neck. (PX1, p. 7) Petitioner returned to work.

On March 24, 2011, Petitioner completed an accident report. On the report, Petitioner listed the date of accident or injury as "*2 weeks ago*". Petitioner also wrote "*didn't think of it as an injury, happened over a period of time*". When explaining how the accident occurred Petitioner wrote "*while decking IP over a period of about 2 wks, I noticed some pain in right shoulder. Thought it was just tightness, so I exercised shoulder and kept working. On 3-24-11 I experienced extreme pain in shoulder, neck and down my back, also could not raise my arm without extreme pain.*". (PX1 p, 34,25)

On March 30, 2011, Petitioner returned to the company clinic. Petitioner reported right shoulder and neck pain since last week. While at the clinic, Petitioner said sometimes she has problems lining up the IPs which can require more force than usual. Dr. Lewis examined Petitioner and noted tenderness at the right trapezius. Petitioner was assessed with a sprain/strain of unspecific muscles and tendons of the shoulder, upper arm and neck. Petitioner returned to work. (PX1, p. 9)

On April 4, 2011 at 6:20 a.m. Petitioner returned to the company clinic complaining of right knee pain from a fall she sustained at work on April 1, 2011. Petitioner said she tripped on a floor mat striking her right knee. Dr. Lewis examined Petitioner and noted slight swelling to the right knee. Petitioner was given an ace wrap and released to return to work. (PX 1, p. 12,13) Later that morning, Petitioner retuned to the company clinic complaining of right shoulder pain. Dr. Lewis was examining Petitioner's right shoulder when she refused to reach posteriorly. Dr. Lewis noted Petitioner could fully extend, adduct and externally/internally rotate the shoulder. Dr. Lewis did not find signs of impingement. Petitioner was advised to continue taking Ibuprofen and she was released back to work. (PX 1, p. 11) After going back to work, Petitioner returned, again, to the company clinic complaining of numbness to her right foot. Petitioner refused to allow Dr. Lewis to palpate her right knee. Dr. Lewis noted Petitioner had full flexion and extension. X-rays of the knee was ordered. (PX 1, p. 14)

Later that day, Petitioner went to Ingalls Memorial Hospital and had X-rays taken. The x-rays showed no acute fractures or subluxations. No joint effusion was found and the articular surfaces were intact. (PX 2) The following day, April 5, 2011, Petitioner

returned to the company clinic complaining of right knee pain. Petitioner was examined by Dr. Lewis. Petitioner refused to fully flex and refused to allow Dr. Lewis to palpitate the knee. Petitioner placing her hands over her knee preventing Dr. Lewis from performing the test. Petitioner was returned to work. (PX 1, p. 16)

On April 6, 2011, Petitioner returned to the company clinic to submit paperwork showing she had received medical treatment earlier in the day and showing she should be off work through April 29,2011. Petitioner was told to return to work because she did not have any objective physical findings. During the visit, Dr. Lewis noted Petitioner had not made any right shoulder complaints since injuring her right knee. (PX 1, 18)

On April 12, 2011, Petitioner returned to the company clinic complaining of right knee pain. Dr. Lewis found no swelling or erythema. Petitioner complained of pain over the superior pole lateral aspect of the patella. Petitioner was returned to work and told to follow up with her personal physician. (PX 1, p. 19)

On April 21, 2011, Petitioner returned to the company clinic complaining of right shoulder pain. Petitioner reported she could not put her arm behind her back and raise it without pain. Petitioner said she has been working as a floater because she has been unable to do her regular job. Dr. Lewis found no swelling or instability. Passive range of motion was full, the cross arm adduction test was negative. Petitioner refused to actively extend or to perform posterior reach test. (PX1, p. 20,21) Petitioner was returned to work.

On April 25, 2011 Petitioner returned to the company clinic complaining of right shoulder and right knee pain. Petitioner reported she sought medical treatment with Dr. Chand, of Southeastern Medical Center, on Aril 21, 2011. During the examination, Dr. Lewis noted tenderness over the AC joint with negative cross adduction test. During the examination, Petitioner would not abduct or fully extend her right arm or perform the posterior reach test. Dr. Lewis found Petitioner had full passive range of motion and her flexion/adduction was normal. Petitioner was returned to regular work because she had been examined multiple times without significant physical findings and because she was uncooperative during examinations. (PX1, p.22)

On April 6, 2011 and April 21, 2011, Petitioner sought treatment with Dr. Chand for her right knee. Petitioner reported falling at work striking her right patella. Dr. Chand examined Petitioner found effusion and tenderness over the patellofemoral areas. Dr. Chand ordered a MRI which showed a mild grade I medical collateral ligament sprain and mild-to-moderate joint effusion with 2.5 Backer cyst. X-rays showed mild degenerative changes in the knee joint including the patellofemoral area. (PX4, p. 8,9)

During the appointments, Dr. Chand also examined Petitioner's right shoulder. Petitioner reported she was experiencing right shoulder pain for three weeks. Dr. Chand found Petitioner's extension was satisfactory, her external rotation was 70% and she had pain during internal rotation. Dr. Chand found Petitioner had tenderness over the shoulder joint. Dr. Chand reviewed the x-rays and found degenerative changes in the

acromioclavicular joint. Dr. Chand diagnosed early frozen shoulder with possible rotator cuff degenerations and degenerative process in the acromioclavicular joint. (PX4, 9) Dr. Chand proscribed Mobic, physical therapy and ordered an MRI.

On April 27, 2011, Petitioner returned to plant the company clinic requesting a copy of her restrictions. Petitioner was advised she does not have any restrictions and Petitioner was sent back to work. (PX1, p. 24)

On July 8, 2011, Petitioner returned to Dr. Chand complaining of right shoulder pain. At this visit, Petitioner denied any other complaints. Dr. Chand noted Petitioner's right shoulder motion had greatly improved and the tenderness was almost gone. Petitioner's abduction was 170, flexion was 170, extension was 40 and rotation was 70%. Dr. Chand reviewed the MRI of May 21, 2011 and wrote "*we are dealing with degenerative changes in the rotator cuff, along head of biceps and acromioclavicular joint*". Dr. Chand proscribed physical therapy, Mobic, Voltenen gel and told Petitioner to follow up in four weeks. (PX4, p.11,12)

On November 17, 2011, Petitioner returned to the company clinic. Petitioner reported she pulled a muscle in her left shoulder while pulling IP down with her left hand. Petitioner said she had left shoulder discomfort radiating up to the left cervical area. Petitioner was examined and her range of motion was within normal limits. Petitioner had discomfort when turning heard to the right. Petitioner was assessed with a left shoulder sprain/strain. (PX1, p. 30) Petitioner was issued restriction for no work at or above shoulder for the day and released. (PX1, p. 31)

On November 29, 2011, Petitioner returned to Dr. Chand complaining of right knee pain from her fall back in April of 2011 and then returned to Dr. Chand, on February 24, 2012, complaining of right shoulder pain and pain over the acromioclavicular joint. Dr. Chand examined Petitioner and found she had limited range of motion with abduction of 110. Dr. Chand noted in his records that Petitioner had full flexion. Dr. Chand records indicate Petitioner denied any elbow or wrist complaints. Petitioner reported that she had been off work due to foot surgery. (PX4, p. 14)

On March 29, 2012, Petitioner returned to Dr. Chand for a follow up appointment. Petitioner reported pain in her right shoulder and cervical spine. Dr. Chand noted Petitioner was complaining of cervical pain on the right side with some numbness over the hand. Dr. Chand's examination found decrease sensation over the right little and ring fingers and part of the middle finder, decreased sensation over the deltoid areas and tenderness over the paraspinal areas. Dr. Chand ordered an x-ray of the cervical spine which showed disc space narrowing in the mid zone. Dr. Chand made a diagnose of cervical strain, osteoarthritis of the cervical spine, right shoulder strain and osteoarthritis of the AC joint. Dr. Chand issued light duty restrictions. (PX 4, p. 17) On August 1, 2012, Dr. Chand ordered MRIs and referred Petitioner to orthopedic evaluation. (PX4, p. 20)

On August 22, 2012, Petitioner was examined by Dr. Ham of Bone & Joint Specialists. During that visit, Petitioner complained of right shoulder pain and neck pain that radiated down to the hand and fingers from the arm. Petitioner reported that she performed a lot of shoulder level repetitive transferring of objects which causes her discomfort in her shoulder. Petitioner said her symptoms started approximately two months following her repetitive activity at Ford. However, Petitioner reported that her neck pain, which radiates down the arm, started sometime this year. The examination showed right shoulder AC joint tenderness and a negative Belly test. Dr. Ham found Petitioner positive for impingement. Dr. Ham assessed right shoulder internal derangement and radicular pain. Dr. Ham ordered an EMG. (PX4 p. 21)

On September 21, 2012, Petitioner returned to Dr. Ham to review the EMG test results. The EMG was normal. Dr. Ham assessed biceps tendinopathy with a painful AC joint and shoulder impingement. Dr. Ham recommended surgery consisting of biceps tenodesis with arthroscopic distal clavicle resection and arthroscopic subacromial decompression. (PX4, p. 23)

On October 9, 2012, Petitioner had surgery at Community Hospital. Dr. Ham performed an arthroscopic SLAP lesion repair on the right side, Bankart lesion repair on the right side and subacromial decompression. The post-operative diagnoses consisted of SLAP lesion/biceps tendinopathy, right side, shoulder impingement syndrome and anterior labrum tear. In the surgical report, Dr. Ham noted he did not find a tear of the biceps tendon but the SLAP area was fraying and unstable. Dr. Ham noted wearing in the anterior rim of the glenoid consistent with early arthritis. Dr. Ham found the supraspinatus, infraspinatus and posterior labral tissues intact. (PX4, p. 24,25)

On November 9, 2012, Petitioner returned to Dr. Ham. During this visit, Dr. Ham noted Petitioner was doing better but she still had some stiffness. Dr. Ham released Petitioner to light duty. (PX4, p. 29)

On December 7, 2012, Petitioner returned to Dr. Ham complaining of head pain that radiated from her neck. Dr. Ham thought the head pain could be caused by a cervical condition and ordered nerve tests and referred Petitioner to Dr. Hyder.

On January 9, 2013, Petitioner returned to Dr. Ham complaining of neck pain, shoulder pain and headaches. Petitioner reported her headache pain was the same level as her neck and shoulder pain. (PX4, p. 31)

On January 29, 2013, Petitioner is examined by Dr. Hyder. Petitioner reported that she injured her neck in march of 2011 during her worker's compensation injury when she hurt her right shoulder. Petitioner said her neck has been progressively getting worse. She rated her neck pain as an 8 out of 10 and her arm pain as 7 out of 10. Dr. Hyder examined Petitioner. Petitioner had a negative seated straight leg raise test, negative femoral nerve stretch, negative Babinski test, negative Hoffmann and negative Clonus tests. Dr. Hyder found Petitioner had no pain with flexion and extension. Petitioner did have a positive Spurling sign. Dr. Hyder reviewed the x-rays and found that Petitioner

had a loss of disc height at various levels but most significantly at C5-C6 level followed by the C4-C5 levels. Dr. Hyder diagnosed cervical radiculopathy and ordered an MRI of the cervical spine. (PR4, p. 32)

On February 6, 2013, Petitioner returned to Dr. Ham for the right shoulder pain. Dr. Ham found Petitioner's external and internal rotation was limited pain to about 30 degrees. Dr. Ham issued restrictions prohibiting repetitive lifting with no more lifting than one pound. (PX4, p. 35)

On February 8, 2013, Petitioner returned to Dr. Hyder to review the MRI scans. During this visit, Petitioner reported numbness and tingling in the C-C6 distribution in her hands. Dr. Hyder found a positive Tinel and median nerve compression tests over the carpal tunnel and found a positive Spurling sign. The MRI showed posterior disc osteophyte complexes at C4-C5 and C5-C6 most significant at C5-C6. Mild foraminal stenosis was found on the right side. Dr. Hyder recommended physical therapy on her cervical spine and braces for the carpal tunnel.

On March 8, 2013, Petitioner returned to Dr. Ham. Petitioner denied doing better. Petitioner reports she was unable to go back to the assembly line. Dr. Ham found the shoulder abduction to be mild to moderately limited otherwise Petitioner's neurovascular examination was intact. Dr. Ham changed Petitioner's restrictions to no lifting more than 25 pounds. (PX4 p. 37) That same day, Petitioner also returned to Dr. Hyder reporting minimal relief from therapy. Dr. Hyder examined Petitioner and found her muscle strength on the right side was 4+/5 in the biceps and 4+/5 with wrist extensions. Dr. Hyder's impression was 2 level disc disease at C4-C5 and C5-C6 with most of the symptoms coming from the C5-C6 level. Dr. Hyder ordered a nerve root block and more physical therapy. (PX4, p. 38)

On April 3, 2013, Petitioner returned to Dr. Ham who noted Petitioner's shoulder motion was improving but not quite normal. Dr. Ham did not order additional therapy and he maintained the work restrictions of no lifting more than 20 pounds. (PX4, p. 38)

On April 30, 2013, Petitioner returned to Dr. Hyder reporting her symptoms completely resolved for one day after the selective nerve root block at C5-C6 level. Dr. Hyder diagnoses Petitioner with degenerative disc disease at C4-C5, issued work restrictions of no lifting more than one pound and recommended surgery at C5-C6. (PX4, p. 40)

On July 3, 2013, Petitioner retuned to Dr. Ham for a follow up visit. Petitioner reported her shoulder was improving but was not entirely normal. Petitioner was advised to return in 6 weeks and Petitioner's work restrictions were renewed. (PX4, p. 44)

On July 22, 2013, Petitioner underwent cervical surgery at St. Mary Medical Center. Dr. Hyder performed an anterior cervical discectomy and fusion at C5-C6 and removed the anterior and posterior osteophytes. The post-surgical diagnosis was cervical radiculopathy at C5-C7. (PX4, p. 46,47) On August 23, 2013, Petitioner returned to Dr.

Hyder. Petitioner reported no significant improvement in her radicular symptoms in her arm. Dr. Hyder recommended physical therapy and released Petitioner to return to work with restrictions of no lifting greater than 25 pounds and no ladders. (PX4, p. 48)

On August 30, 2013, Petitioner returned to Dr. Ham who found Petitioner's AC joint was no longer tender and her strength was intact. Dr. Ham released Petitioner from all shoulder restrictions and found Petitioner to be near maximum medical improvement.

On October 2, 2013, Petitioner followed up with Dr. Ham who noted Petitioner was doing well postoperatively. Dr. Ham found Petitioner's shoulder had full stable motion and good strength. He determined Petitioner was at MMI and released her from care for her shoulder. (PX4, p. 51)

On October 4, 2013, Petitioner returned to Dr. Hyder who noted Petitioner's muscle strength was 5 out of 5 and she was doing excellent. Dr. Hyder released Petitioner to return to work full duty for her cervical condition. (PX4, pg. 52)

On October 15, 2013, Petitioner returned to Dr. Hyder. During this visit, Petitioner complained of swelling in her neck, headaches and migraines. Petitioner reported her radicular symptoms, she was previously experiencing, down her right arm were mostly resolved. Petitioner was told to return in 3 months. (PX4, p. 53)

On January 10, 2014, Petitioner followed up with Dr. Hyder. Petitioner reported aches and pains in her neck and right shoulder. Dr. Hyder noted Petitioner's muscle strength was 5 out of 5. Petitioner was advised to follow up in 6 months. (PX4, p 54)

On January 17, 2014, Petitioner returned to Dr. Ham complaining of right shoulder pain. Petitioner reported the pain radiated from the shoulder to her wrist. Petitioner also complained of neck issues. Dr. Ham noted Petitioner's range of motion was stable without discomfort, Petitioner's AC joint was tender upon palpation and Petitioner's bicep tendon was also tender upon palpation. Dr. Ham ordered cervical and right shoulder MRIs. (PX4, p. 55)

On February 17, 2014, Petitioner returned to Dr. Ham complaining of AC joint pain and numbness and tingling. Dr. Ham reviewed the MRIs and found the MRIs determined the MRI's did not show anything. Dr. Ham thought that Petitioner may have carpel tunnel syndrome and he ordered an EMG. (PX4, p. 56)

On March 10, 2014, Petitioner followed up with Dr. Ham to review the EMG results. Petitioner reported she was now experiencing pain around the elbow and shoulder. In his records, Dr. Ham noted that during Petitioner's last visit she was complaining of AC joint pain. Petitioner reported she was having problems in all her fingers but more so in the 3 ulnar digits. Dr. Ham reviewed the EMG, which was found to be normal. Dr. Ham's impression was compression neuropathy because of the Petitioner's reports of symptoms despite the negative EMG, cubital tunnel syndrome, lateral epicondylosis and AC joint arthrosis. (PX4, p.57)

On April 2, 2014, Petitioner returned to Dr. Ham complaining of severe pain of her axillary area which radiates up to her head and headaches. Petitioner reported that she had been doing repetitive work which aggravates her discomfort. Petitioner told Dr. Ham she was unable to do her repetitive job. In is records, Dr. Ham noted that during her last visit Petitioner was complaining of lateral epicondylosis and painful AC joint symptoms. Dr. Ham wrote in his records that "*today she seems to be complaining of different areas with more discomfort around the ancillary area with headaches and numbness...Patient had similar issue in the past concerning her job of repetitive assembly work and I think she may not be fit for this kind of work. I recommend a permanent change of position where she does not do repetitive work activities.*" Dr. Ham found the EMG study was negative and her referred Petitioner to a neurologist. (PX4, p. 58)

On April 30, 2014, Petitioner returned to Dr. Ham with new complaints. Dr. Ham wrote in his records that "*The patient returns and now she is having shoulder pain on the left.* ". Dr. Ham's records indicate that Petitioner requested permanent restrictions on her left side so she could obtain different type of work from her employer. Dr. Ham agreed to issue permanent restrictions of no repetitive activities for both shoulders. Dr. Ham's examination found Petitioner had a negative O'Brien test, negative Belly test and Petitioner's rotator cuff strength was intact and her neurovascular examination was also intact. Dr. Ham found mild impingement for only the left shoulder. (PX4, p. 59)

On May14, 2014, Petitioner returned to Dr. Ham. Petitioner reported that she is now content since her permanent restrictions were issued. Dr. Ham's examination of found Petitioner was freely moving her shoulder without discomfort and her neurovascular examination was intact. (PX4, p 60)

On May 6, 2014, Petitioner began treating with Dr. Salberg of Northern Indiana Neurological Institutes. Dr. Salberg's records show Petitioner was a 50-year-old female who presents with neck pain. Petitioner reported the onset of her neck pain was immediately after she was injured operating a hoist that malfunctioned. Petitioner said she had been experiencing neck pain for 3 years. Dr. Salberg found Petitioner's symptoms were in the mid cervical area which radiated to the right trapezius, right chest, right shoulder, right arm, right upper arm, right forearm, right hand and right scapular. Additionally, Petitioner reported that she experiences headaches for 25 days out of every month for the past 3 years and she also has been experiencing leg pain since July of 2013, after her cervical fusion surgery, and a sleep disorder. Dr. Salberg ordered cervical and lumbar MRIs and EMGs. (PX5, p. 16)

Petitioner returned to Dr. Salberg on July 25, 2014 to review the tests results. The EMG of both upper extremities were normal. The EMG of the lower extremities found mild right S1 radiculopathy without active ongoing denervation. The lumbar MRI revealed new mild, left-sided, foraminal stenosis at L4-L5 and stable mild spondylosis without significant central canal or foraminal stenosis from L1 through L4 and L5 through S1. The cervical MRI found a small right paracentral disc protrusion at C4-C5, postsurgical changes without stenosis at C5-C6 and a small paracentral disc osteophyte

complex at C6-C7. Dr. Salberg recommended physical therapy for the lumbar and cervical radiculopathy and ordered a MRI of the thoracic spine. (PX5, p. 21-25)

On October 29, 2014, Petitioner returned to Dr. Salberg to discuss test results. Dr. Salberg noted the thoracic MRI revealed degenerative disc disease, right paracentral/subarticular disc protrusion at T10-T11 and thoracic dextroscoliosis. (PX5, p. 31).

On November 18, 2014, Petitioner returned to Dr. Salberg complaining of right groin pain which radiated down the medial aspect of her leg. Petitioner reported she was experiencing headaches less frequently. Petitioner said she believes her headaches were connected to her right shoulder problem. Dr. Salberg ordered an MRI of the right shoulder. (PX5, p.32-37)

On December 9, 2014, Petitioner returned to Dr. Salberg complaining of right hip pain. Petitioner said that she had been experiencing the right hip pain for 2 months. Dr. Salberg ordered a right hip MRI. (PX5, p. 38-41). On February 10, 2015, Petitioner returned to Dr. Salberg to discuss tests results. Dr. Salsberg found the right shoulder MRI did not show any pathology. Dr. Salsberg ordered a bilateral upper EMG and referred Petitioner to Dr. Diveris for her right hip complaints. (PX5, p. 42-45)

On April 21, 2015, Petitioner returned to Dr. Salberg complaining of right arm pain. Dr. Salberg recommended additional cervical physical therapy. (PX5, p. 49)

On October 10, 2015, Petitioner returned to Dr. Salberg complaining of low back pain and that her symptoms were not improving. Dr. Salberg ordered cervical and lumbar MRIs and upper and lower EMGs. (PX5, p. 50-53) The hip MRI showed degenerative changes at the sacroiliac joints bilateral. The right shoulder MRI showed postsurgical changes and a small amount of fluid within the subacromial-subdeltoid bursa. The thoracic MRI showed degenerative disc disease at T2-3, T4-5 and T6-7, facet arthropathy in the upper thoracic spine, small central disc protrusion contacting the cord at T6-7,right paracentral/subarticular disc protrusion causing mild cord impingement at T10-11 and thoracic dextroscoliosis. (PX5, p. 58-67) The cervical MRI showed a small right paracentral disc protrusion at C4-5, postsurgical changes without significant central canal or foraminal stenosis at C5-6, a small paracentral osteophyte at C6-7 and no evidence of abnormal cord enhancement. The lumbar MRI showed stable mild spondylosis without significant central canal foraminal stenosis. (PX5, p.74-77). The upper and lower EMG studies were normal. (PX5, p. 121)

On April 3, 2017, Petitioner returned to Dr. Ham. The examination of the right shoulder revealed mild impingement. Dr. Ham prescribed Mobic. (PX11, p. 7-9). On April 26, 2017, Dr. Ham assessed Petitioner with mild right shoulder rotator cuff tendinopathy. Dr. Ham issued permanent work restriction of no repetitive motion, pushing, or pulling with either arm. Dr. Ham did not recommend any treatment. (PX11, p. 10-14).

At trial, Petitioner testified that when she normally woke up in the morning, her right shoulder was in pain. (T46-47). She noted as the day goes on, her pain comes and goes. (T47). If Petitioner did any heavy lifting, such as 10 to 15 pounds, she testified that the pain got worse in both her neck and right shoulder. (T47). She testified that when going to sleep, she had to put her right shoulder and neck in a certain position so she could sleep without pain. (T49). She stated that she uses "My Pillow." (T49). She testified that she currently takes Mobic 4 to 5 times a week. (T45).

Section 12 Examination of Dr. Guido Marra

On June 25, 2012 Petitioner attended an IME with Dr. Marra. (PX8). Petitioner reported she works on an assembly line and she moves heavy parts with a machine assist into position and bolts them into place. Petitioner said, at times, the machine did not work very well and moving the part which requires a significant amount of force. Petitioner stated her activities, when the machine is out of alignment, caused her right shoulder pain. Petitioner told Dr. Marra that prior to April she had no problems with her shoulder. (PX8).

Dr. Marra noted when reviewing some of Petitioner's treatment records, it the right shoulder is listed as the left shoulder. Petitioner assured Dr. Marra that she has no problems with her left shoulder and her problems were restricted to her right shoulder. (PX 8) Dr. Marra opined Petitioner may have symptomatic articular-sided partial thickness rotator cuff tear with impingement syndrome which he related to Petitioner's job duties. Dr. Marra did not feel Plaintiff's April 1, 2011 fall contributed to her right shoulder condition. Dr. Marra said "*Based on her description of the mechanism of injury I do feel that this is a competent cause of impingement syndrome.*" Dr. Marra recommended 6 weeks of physical therapy, subacromial corticosteroid injections and he would consider arthroscopic decompression if the treatment did not work. (PX8).

Section 12 Examinations and Testimony of Dr. Bryan Neal

On January 21, 2013, Petitioner attend an IME with Dr. Neal. (RX1). Dr. Neal noted Petitioner arrived at 10:05 a.m. Dr. Neal asked Petitioner questions about her history and medical treatment. At 11:30 a.m., Dr. Neal testified he met with another patient for 7 to 8 minutes and when he returned, at 11:45 a.m., the Petitioner said she was leaving because she needed to take her son to physical therapy at 2:00 p.m. Because Petitioner left, Dr. Neal was unable to perform a physical examination.

Petitioner returned to Dr. Neal for another IME on February 27, 2013. (RX1). Dr. Neal tried asking Petitioner questions regarding her condition and recent treatment. Petitioner would not answer any questions. Specifically, he noted that when he asked Petitioner about any additional treatment since the January 21, 2013 evaluation, Petitioner refused to answer the question and she pulled out her cell phone and appeared to replying to a text.

Dr. Neal performed a physical examination and took x-rays. Dr. Neal noted the examination of Petitioner was high unusual. Specifically, Dr. Neal noted that applying the "tiniest amount of pressure" to Petitioner's head caused her to complain of pain and about 45-60 seconds later. He noted he could barely touch the mid shaft of the clavicle *"without some withdrawal of pain."* Dr. Neal testified the Petitioner's subjective complaints were not plausible.

Petitioner returned to Dr. Neal for a third time on January 28, 2015. Petitioner would not reply to Dr. Dr. Neal's questions and Petitioner would not give Dr. Neal consent to examine her. (RX1, p. 50)

At trial, Petitioner testified to arriving to the IME appointment on time, first stating she recalled arriving at 10:00 a.m., and later, after being showed an IME notice letter, she testified that she arrived at 9:30 a.m. (RX8; T69-70). Petitioner testified she left the examination with Dr. Neal because she had to pick up her son from school. (T72) At trial, Petitioner testified that when she felt Dr. Neal was asking redundant questions, she stopped answering them. (T73). Petitioner testified she refused to answer Dr. Neal's questions at the second IME because she felt Dr. Neal was asking her redundant question. (T72) Petitioner testified she did not answer Dr. Neal's questions at the third IME because she felt that she was there for an examination and she felt the questions were not necessary and the questions did not make sense to her. (T.41,42)

Dr. Neal opined Petitioner's current cervical issues were unrelated to the work accident and that Petitioner was MMI. (RX1). Dr. Neal also opined that Petitioner's right shoulder condition was not related to any work incident because Petitioner reported that her right shoulder pain began weeks prior to the claimed accident date. After the third appointment with Dr. Neal, on January 28, 2015, he opined Petitioner did not need permanent work restrictions. (RX3).

Section 12 Examination by Dr. Kathleen Weber

On January 23, 2017, Respondent obtained an IME with Dr. Weber of Midwest Orthopaedics at Rush. Petitioner reported to Dr. Weber she sustained an injury to her right shoulder and her cervical spine on March 10, 2011. Petitioner said she believes she was injured when a machine on the assembly would occasionally not work correctly and she would have to lift the board, weighing approximately 100 pounds, and shove it into position.

Dr. Weber examined Petitioner's right shoulder and found Petitioner's current complaints of pain to be of an unknown etiology. Dr. Weber noted Petitioner complained of significant right shoulder dysfunction but Petitioner had full rotator cuff strength. Dr. Weber also noted Petitioner did not display any compensatory movements and she had inconsistent impingement findings. Dr. Weber found that Petitioner's subjective complaints were not supported by any objective findings. Dr. Weber further opined Petitioner ongoing subjective pain had no correlation or causal relationship to her March

2011 accident. Dr. Weber found that Petitioner sustained a right shoulder subacromial impingement from her repetitive work and Petitioner was released to return to full duty work, without restrictions, and was found to be at MMI for the right shoulder on October 2, 2013. Dr. Weber opined that Petitioner's current non-specific right shoulder pain was not related to her March 2011 work accident.

Dr. Weber examined Petitioner's left shoulder. The examination was normal with no objective findings or subjective complaints. Dr. Weber opined there was no causal relationship in regards to Petitioner's left shoulder condition and a work accident in March of 2011.

Dr. Weber examined Petitioner's cervical spine. The examination revealed normal motor strength, sensation and reflexes. Dr. Weber found that Petitioner had no open motor neuron findings or evidence of radiculopathy. Dr. Weber found that Petitioner had subjective complaints about the musculature of the neck without any signs of muscle spasms or hypertonicity. Dr. Weber noted Petitioner's complaints of radiation did not correlate to a dermatomal pattern and Petitioner had Petitioner had four normal EMG studies from September of 2012 through February of 2015. Dr. Weber opined that Petitioner's cervical complaints were not related to her alleged work accident of March 2011. Dr. Weber noted Petitioner may have made some initial musculature complaints but there were no further neck pain complaints until November of 2011 and there were no radicular symptoms for approximately a year after the initial accident. Dr. Weber opines there was no correlation to Petitioner's work mechanisms and the timing of her March 2011 work accident. Dr. Weber further opines Petitioner's cervical fusion surgery was not related to her alleged work accident of March of 2011. Dr. Weber found Petitioner has current complains of non-specific cervical pain with radiating complaints without a particular dermatomal pattern. (RX3).

Vocational Report and Testimony of Steven Blumenthal

At Petitioner's attorney's request, Petitioner was evaluated by a vocational counselor, Mr. Blumenthal, who authored a report dated May 5, 2016. (PX10). In Mr. Blumenthal's report, he noted that Petitioner was interested in office-type work but she lack of proficiency in Microsoft office "*was hindering her ability to obtain office desk-based employment which she is interested in.*" (PX10). Overall, Mr. Blumenthal opined that with computer training and job placement Petitioner could find a job making $10.00 to $14.50 an hour. (PX10).

During Mr. Blumenthal's deposition, he testified that Petitioner was "*on a job search*" and "*was looking for office desk-based employment.*" (PX10, p. 19-20). He also testified that Petitioner reported to him that "*she was already performing a job search for desk-based employment*". (PX10, p. 48). Mr. Blumenthal testified that he relied upon the statements Petitioner made to him regarding her work history, educational background, and job efforts at the time in reaching his final conclusions. (PX10, p. 20). At trial, Petitioner was asked her job search. Petitioner testified that she did not conduct a job search. (T83) Petitioner testified she did not look for work because she was advised by

the union not to look for work because if she found a new job she would lose her seniority. (T85,86)

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998). An employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888 (2007).

The Arbitrator found the testimony of the Petitioner not to be credible.

WITH RESPECT TO ISSUE (C) WHETHER AN ACCIDENT OCCURRED THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

To obtain compensation under the Act, a claimant bears the burden of showing by a preponderance of the accidence, that the claimant has suffered a disabling injury which arose out of and in the course of his employment. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 203, 797 N.E.2d 665, 671 (2003). In the course of employment refers to the time, place and circumstances surrounding the injury and, generally, must occur within the time and space boundaries of the employment. *Id.* An injury "arises out of" employment when "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." *Id* at 203, 797 N.E.2d at 672.

An employee who suffers a repetitive-trauma injury must meet the same standard of proof as an employee who suffers a sudden injury. *City of Springfield v. Illinois Workers' Compensation Comm'n*, 388 Ill.App.3d 297, 313, 901 N.E.2d 1066, 1079 (2009) The employee must allege and prove a single, definable accident that manifests itself on a specific date. *White v. Workers' Compensation Comm'n*, 374 Ill.App.3d 907, 873 N.E.2d 388, 391 (2007) (*quoting Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 530, 505 N.E.2d 1026, 1028 (1987)). The phase manifests itself signifies the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person. *Id.* Further there must be a showing that the injury is work related and not the result of a normal degenerative aging process. *Peoria County Belwood Nursing Home*, 115 Ill.2d at 530, 505 N.E.2d at 1028.

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proven by the preponderance of the credible evidence that Petitioner suffered an injury that arose out of and the course of her employment by Respondent on March 24, 2011 as set forth more fully below.

Petitioner testified that after two weeks of lifting the machine, when the machine was not aligned, she started to feel some tension or aching muscles in her right shoulder and neck. (T25) Petitioner testified on March 24, 2011, while performing her daily work she noticed her right shoulder and neck was racked with pain. (T25) On that day, Petitioner went to the Ford Motor Company's occupational health clinic. (T26) Petitioner was examined by a company doctor who observed tenderness at the right trapezius and diagnosed a right shoulder and neck sprain/sprain. Petitioner told the company doctor she had been having pain for about two weeks but her pain was worse today. (PX1, p. 7) Petitioner completed an accident report. On the report, Petitioner listed the date of accident or injury as "*2 weeks ago...didn't think of it as an injury, happened over a period of time*". When explaining how the accident happened Petitioner wrote "*while decking IP over a period of about 2 wks, I noticed some pain in right shoulder. Thought it was just tightness, so I exercised shoulder and kept working. On 3-24-11 I experienced extreme pain in shoulder, neck and down my back, also could not raise my arm without extreme pain.*". (PX1 p, 34,25)

The Arbitrator finds that on March 24, 2011, Petitioner sustained an accidental injury to her right shoulder which arose out of and in the course of her employment. The Arbitrator finds that Petitioner had an accidental injury which arose out of and in the course of her employment by Respondent when Petitioner went to the company's occupational health clinic, reported the aggravation of her pain, received treatment and completed the accident report identifying the work-related activities aggravated her condition.

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

In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). Even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied if it can be shown that the employment was a causative factor. *Id.*

Petitioner sought medical treatment for her right shoulder, left shoulder, cervical spine, right hip, lumbar spine and carpal tunnel syndrome. Each of Petitioner's

complaints arose at different times. Petitioner alleges her condition was the result of certain repetitive tasks she performed while on the ignition panel line. It is important to note that Petitioner began working on the ignition panel line in January of 2011 and her symptoms manifested on March 24, 2011. Petitioner did not allege her condition was the result of performing the repetitive nature of her general duties. Petitioner testified and told various doctors her injuries were the result of lifting the machine holding the ignition panel when it was out of alignment and pushing the panel to the correct positon. Petitioner testified the machine became out of alignment "from time to time". (T22) Petitioner testified the ignition panel weighed approximately 100 pounds but Petitioner acknowledged the machine held the ignition panel and she was not lifting the full weight of the ignition panel. (T23) Petitioner failed proffer testimony regarding the number of times the machine would be alignment causing her to lift the panel during the three months Petitioner worked on the ignition panel line.

Petitioner told Dr. Weber that she believes she injured her right shoulder when a machine on an assembly line would occasionally would not work correctly and she had to lift the panel and push it into place using force. (RX3) Petitioner told Dr. Marra that, at times, the machine assist did not work well and she had to use significant force and this caused her shoulder problem. (PX8) Based upon Petitioner's history of the machine being out of alignment and the activities needed to secure the ignition panel, Dr. Marra and Dr. Weber opined that Petitioner's right shoulder impingement was caused by her work-related activities.

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proved by the preponderance of the credible evidence that her right shoulder subacromial impingement for which she underwent surgery and was subsequently released to return to work full duty and reached MMI, on October 2, 2013, was causally related to her work injury of March 24, 2011. However, the Arbitrator finds that Petitioner failed to prove by the preponderance of the credible evidence that her current right shoulder condition is causally related to her work injury or March 24, 2011. The Arbitrator further finds the Petitioner failed to prove that her left shoulder, cervical spine, lumbar spine, thoracic spine, right him, headaches and carpal tunnel are causally related to her work injury of March 24, 2011 as set forth more fully below.

Dr. Ham, who performed the right shoulder surgery, released Petitioner to full duty without restrictions on August 30, 2013. At that time, Dr. Ham noted Petitioner's AC joint was not tender and her strength was intact. On October 2, 2013, Dr. Ham found that Petitioner's shoulder had full stable motion and she was maximum medical improvement. (PX4, p. 51) Dr. Marra, who performed an IME, found that based upon the Petitioner's description of the mechanism of the injury, this was a competent cause of impingement syndrome. Dr. Weber, who also performed an IME, opined Petitioner sustained a right shoulder subacromial impingement from repetitive work at chest or above the chest level. However, Dr. Weber opined that Petitioner's current non-specific right shoulder pain was not related to Petitioner's work accident of March 2011. The Arbitrator finds that Dr. Weber incorrectly listed the date of injury as March 1, 2011 but

the error was a scrivener's error which does not affect the substance of Dr. Weber's opinions because the Petitioner alleges a repetitive injury and Dr. Weber received the original treatment records. The Arbitrator finds the opinions of Dr. Weber to be persuasive.

Dr. Weber examined Petitioner's right shoulder and found Petitioner's current complaints of pain to be of an unknown etiology. Dr. Weber noted Petitioner complains of significant right shoulder dysfunction but Petitioner had full rotator cuff strength nor does Petitioner display any compensatory movements and Petitioner had inconsistent impingement findings. Dr. Weber found Petitioner's current right shoulder complaints to be subjective in nature and were not consistent with any objective findings. Dr. Weber opined that Petitioner currently has subjective right shoulder complaints that had no correlation or causal relationship to her March 2011 work accident. Dr. Neal noted the examination of Petitioner was high unusual. Specifically, Dr. Neal noted that applying the "tiniest amount of pressure" to Petitioner's head caused her to complain of pain and about 45-60 seconds later. He noted he could barely touch the mid shaft of the clavicle *"without some withdrawal of pain."* Dr. Neal testified the Petitioner's subjective complaints were not plausible.

The Arbitrator finds the testimony of the Petitioner not to be credible. Petitioner provided inconsistent histories to the doctors. Throughout her treatment Petitioner's symptoms would change and so would the body parts. Petitioner complained of radicular symptoms which failed to correlate to any objective findings or EMG studies. The Arbitrator finds the opinions of Dr. Marra, Dr. Neal and Dr. Weber to be persuasive. The Arbitrator finds the Petitioner's inconsistent histories and complaints adversely impacted the weight to be given to the opinions of the treating physicians. Based upon the above, the Arbitrator finds that Petitioner has failed to prove by the preponderance of the evidence that her current right shoulder complaints, after reaching MMI on October 2, 2013, are causally connected to her work injury of March 24, 2011.

Regarding Petitioner's cervical condition, the Arbitrator finds the Petitioner failed to prove by the preponderance of the evidence that her cervical condition was causally related to her work accident of March 24, 2011. Petitioner complained of neck pain to Dr. Chand on March 29, 2012 yet Petitioner had been treating with Dr. Chand since July 8, 2011. (PX4) Petitioner's first radicular complaints occurred on August 22, 2012. On August 22, 2012, Petitioner told Dr. Ham her neck pain started in 2012. (PX4, p.21) However, Petitioner told Dr. Salberg, on May 6, 2014, the onset of her neck pain immediately when she also injured her shoulder after a hoist she was operating, malfunctioned. (PX 5, p. 16)

On June 25, 2012, Petitioner failed to tell Dr. Marra she was experiencing neck pain during her examination. In April of 2012, Petitioner reported, to Dr. Chand, that she was having right shoulder and she did not report any neck pain.

Dr. Weber opined that Petitioner's cervical complaints were not related to her alleged March 2011 work accident. Dr. Weber noted Petitioner did not have any radicular

type symptoms for approximately a year after her work accident nor was there any correlation between Petitioner's work mechanisms and the timing of her March 2011 work accident. Dr. Weber further opined that Petitioner's cervical fusion surgery was not related to her alleged work accidents or March of 2011.

Based upon Petitioner's inconsistent histories and inconstant symptoms, the Arbitrator finds the opinions of Dr. Weber and Dr. Neil to be persuasive. The Arbitrator finds the Petitioner failed to proffer a credible medical opinion that her cervical condition and subsequent fusion surgery was causally related to her work injury of March 24, 2011. In cases relying on the repetitive trauma concept, the claimant generally relies on medical testimony to establish a causal connection between the claimant' work and the claimed disability. See *Quaker Oats Co. v. Industrial Commission*, 414 Ill. 326 (1953). 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 upon guess, surmise, or conjecture. *Wilfert v. Retirement Board*, 318 Ill.App.3d 507 (1st Dist. 2000)

Regarding Petitioner's thoracic spine, lumbar spine, right hip, left shoulder, headaches and carpal tunnel syndrome the Arbitrator finds that the Petitioner failed to prove by a preponderance of credible evidence these conditions were casually related to her work accident of March 24, 2011. When a preexisting condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting condition such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *St. Elisabeth's Hospital v. Worker's Compensation Commission,* 864 N.E.2d 266, 272 (5th Dist 2007)

The Arbitrator finds that Petitioner failed to prove the various conditions she subsequently received treatment were causally related to her work accident of March 24, 2011. Several of the conditions are not listed on Petitioner's Application of Adjustment of Claim. (Arb. Ex. 1) Petitioner's various conditions manifested at different times but all more than a year after her work accident. Petitioner failed to proffer medical opinions her various subsequent medical conditions were caused by her work accident of March 24, 2011. December 9, 2014, Petitioner reported that she was having hip pain for the past 2 months. On December 9, 2014, Petitioner complained that she was having headaches because of her shoulder injury. On April 21, 2015, Petitioner reported right arm pain. On October 10, 2015, Petitioner reported lumbar pain. Petitioner proffer no medical opinions that her thoracic, lumber, hip, left shoulder, headaches and carpal tunnel conditions were caused, aggravated or accelerated by her work accident of March 24, 2011. Therefore, the Arbitrator finds Petitioner failed to prove her various conditions were causally connected to her work-related accident of March 24, 2011 and her conditions were not the result of normal degenerative process of a preexisting condition.

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

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,* 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

Petitioner claims Respondent is liable for the medical bills of ATI, in the amount of $5,163.52, Bone & Joint Specialist, in the amount of $847.38, and Northern Indiana Neurological Institutes, in the amount of $5,378.96. (Arb. Ex. 1)

Dr. Weber and Dr. Marra opined that Petitioner's medical treatment consisting on the nonsteroidal anti-inflammatory medicines, right shoulder physical therapy, right shoulder subacromial injections, right shoulder arthroscopic surgery and right shoulder post-surgery physical therapy were medical reasonable and necessary related treatment. The Arbitrator orders Respondent to pay reasonable and necessary medical services, pursuant to the medical fee schedule, for Petitioner's pre-surgery right shoulder physical therapy, right shoulder subacrominal injection, right shoulder arthroscopic surgery and right shoulder post-surgery physical therapy thought the date of MMI on October 2, 2013, as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for all non-occupational 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.

The Arbitrator finds that Respondent is not responsible for the medical bills for Neurological Institutes and the medical bills of Bone & Joint and ATI incurred after October 2, 2013 and/or for treatment for conditions other than the right shoulder impingement and treatment found to be reasonable and necessary related treatment as outlined above.

WITH RESPECT TO ISSUE (K), WHAT TEMPORARY TOTAL DISABILITY BENEFITS ARE DUE, IF ANY, THE ARBITRATOR FINDS AS FOLLOWS:

To be entitled to receive TTD the claimant must show not only that he or she did not work but also that he was unable to work. *Interstate Scaffolding, Inc. v. The Illinois Workers' Compensation Commission,* 236 Ill.2d 132, 923 N.E.2d 266, 337 Ill.Dec. 707 (2010).

Petitioner claims to be entitled to temporary total disability benefits from 10/9/2012 thought 11/07/2012 and 7/22/2013 through 10/4/2013. (Arb.Ex.#1) Petitioner was released to return to work full duty for her right shoulder injury on August 30, 2013 and was found to be at MMI on October 2, 2013. Respondent did not proffer evidence

showing that work within Petitioner's restrictions was available to Petitioner while her right shoulder restrictions existed. The Arbitrator orders Respondent to pay temporary total disability benefits from 10/9/2012 through 11/7/2012 and from 7/22/2013 through August 30, 2013. The Arbitrator finds that Respondent is not responsible to pay temporary total disability benefits after Dr. Ham released Petitioner to full duty on August 30, 2012.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTEND OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner is seeking a wage differential award pursuant to Section 8(d)(1) of the Act. To qualify for a wage differential award, a claimant must prove: (1) partial incapacity which prevents pursuit of his or her usual and customary line of employment and (2) impairment of earnings. *Yellow Freight Systems v. IIC*, 351 Ill.App.3d 789, 794-5 (1st Dis., 2004).

As stated above, the Arbitrator found that Petitioner's cervical condition, non-specific right shoulder complaints and various other conditions were not causally connected to her work injury of March 24, 2011. The Arbitrator found that Petitioner's right shoulder impingement with subsequent surgery as being causally connected to her work injury of March 24, 2011. Dr. Ham released Petitioner back to work on August 30, 2012, without restrictions, and found that Petitioner was at MMI on October 2, 2013. At that time, Petitioner's AC joint was no longer tender and her strength was intact. On October 2, 2013, Dr. Ham found Petitioner's shoulder to have full stable motion and good strength.

On October 9, 2012, Dr. Ham performed an arthroscopic SLAP lesion repair on the right side, Bankart lesion repair on the right side and subacromial decompression. The post-operative diagnoses consisted of SLAP lesion/biceps tendinopathy, right side, shoulder impingement syndrome and anterior labrum tear. In the surgical report, Dr. Ham did not find a tear of the biceps tendon but he found the SLAP area was fraying and unstable. Dr. Ham found wearing in the anterior rim of the glenoid consistent with early arthritis. Petitioner's supraspinatus, infraspinatus and posterior labral tissues were intact. (PX4, p. 24,25)

The Arbitrator finds the Petitioner's current restrictions, issued by Dr. Ham, include conditions unrelated to Petitioner's work accident of March 24, 2011. Dr. Ham's records during Petitioner's last visit Dr. Ham wrote "*today she seems to be complaining of different areas with more discomfort around the ancillary area with headaches and numbness...Patient had similar issue in the past concerning her job of repetitive assembly work and I think she may not be fit for this kind of work. I recommend a permanent change of position where she does not do repetitive work activities.*" The Arbitrator finds that Petitioner's current restrictions include various body parts not causally related to her work accident of March 24, 2011. Dr. Weber opined that Petitioner does not have any work restrictions related to her March 24, 2011 work accident and Petitioner's current non-specific right shoulder pain is unrelated.

The Arbitrator finds Petitioner is claiming she is prevented from pursuing her usual and customer line of employment because of subsequent and unrelated conditions.

Petitioner had not secured subsequent employment which would show that Petitioner suffered an actual decrease in wages. Petitioner is relying upon the testimony of Mr. Blumenthal, the vocational expert hired by her attorney, to establish the decrease in Petitioner's waged. Petitioner told Mr. Blumenthal that she was conducting a job search. (PX10, p. 19-20). However, Petitioner testified that she never conducted a job search. The Arbitrator finds the opinions of Mr. Blumenthal not to be persuasive because his opinions are based upon inaccurate information provided by Petitioner. The Arbitrator further finds that Petitioner took herself out of a job search.

Based upon the above, the Arbitrator finds the Petitioner failed to prove she was permanently and partially incapacitated from pursuing her usual and customary line of employment as the result of her work-related accident of March 24, 2011.

At trial, Petitioner testified that when she normally woke up in the morning, her right shoulder was in pain. (T46-47). She noted as the day goes on, her pain comes and goes. (T47). If Petitioner did any heavy lifting, such as 10 to 15 pounds, she testified that the pain got worse in both her neck and right shoulder. (T47). She testified that when going to sleep, she had to put her right shoulder and neck in a certain position so she could sleep without pain. (T49). She stated that she uses "My Pillow." (T49). She testified that she currently takes Mobic 4 to 5 times a week. (T45).

Dr. Ham, who performed the right shoulder surgery, released Petitioner to full duty without restrictions on August 30, 2013. At that time, Dr. Ham noted Petitioner's AC joint was no longer tender and Petitioner's strength was intact. Dr. Ham found Petitioner reached MMI on April 20, 2013. At that time, Petitioner could return to prior occupation but for her unrelated cervical condition. On September 18, 2012 Petitioner had a normal EMG study. On March 5, 2014 and February 16, 2015 Petitioner had additional EMG studies also found to be normal. During Dr. Weber's examination of January 23, 2017, Petitioner's external rotation was 5/5 bilaterally, Speed's and Yergason, Hawkins, were negative. The Champagne Toast and Spill tests were negative. The O'Brien's test was negative. There was no abnormal scapular dyskinesia or winging noted with both resting and motion. Petitioner had no compensatory movements with motion. The Neer's test was positive on the right and negative on the left.

Based on the above, and the Record, taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 30% loss of use of a man as a whole pursuant to §8(d)2 of the Act.

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

Angela D. West,

Petitioner,

vs.

NO: 12 WC 06256

18IWCC0392

Ford Motor Company,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 5, 2017 is hereby affirmed and adopted.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,300.00. 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.

JUN 18 2018

DATED:
o-05/24/2018
MJB/sk
44

Michael J. Brennan

David L. Gore

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
AMENDED

WEST, ANGELA D
Employee/Petitioner

Case# **12WC006256**
12WC006255

FORD MOTOR COMPANY
Employer/Respondent

18IWCC0392

On 10/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.19% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
JASON P CARROLL
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
DANIEL A BRAINARD
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)SS.

COUNTY OF COOK)

18IWCC0392

☐ 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
AMENDED ARBITRATION DECISION

Angela D. West
Employee/Petitioner

v.

Ford Motor Company
Employer/Respondent

Case # 12 WC 006256

Consolidated with 12 WC 006255

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **June 9, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. x Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. x Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. 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 **April 1, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $34,259.68; the average weekly wage was $658.84.

On the date of accident, Petitioner was **47** years of age, ***single*** with **2** dependent children.

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

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

Respondent is entitled to a credit for any amounts paid in medical bills through its group medical plan pursuant to Section 8(j) of the Act.

ORDER

The Arbitrator finds the Petitioner's **right knee condition was** causally related to the work accident of April 1, 2011.

Respondent shall pay the Petitioner the sum of **$395.30 per week** for a further period of **10.75 weeks** as provided under **Section 8(e)** of the Act because the injuries sustained caused permanent partial disability to the extent of **5%** loss of use of **right leg** as provided under the Act.

Respondent shall pay Petitioner compensation that has accrued from April 1, 2011 through June 9, 2017, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

10/5/17
Date

OCT 5 - 2017

INTRODUCTION

On February 21,2012, Petitioner, Angela D. West, filed a claim with the Illinois Workers' Compensation Commission (12WC226255), with a date of accident of 3/24/2012. The Application For Adjustment of Claim lists the body part as "R shoulder and body". Regarding how the accident occurred, the Application For Adjustment of Claim states "at work". The issues in dispute are accident, causal connection, liability for medical expenses, TTD benefits and nature and extend of the injury. (Arb. Ex #1) Petitioner filed an additional claim with a date of accident of 4/1/11 (12WC006256). The Application For Adjustment of Claim lists the body part as "R knee". Regarding how the accident occurred, Petition Application for Adjustment of Claim states "Injured at work. Tripped and fell on ergonomic mat". The issues in dispute are accident, causal connection and nature and extend of the injury. (Arb. Ex. #2) For both cases, the Parties stipulated to employee and employer relationship, notice, and average weekly wage of $658.84. (Arb. Ex.# 1 and 2) The cases were consolidated and a hearing was held on June 9, 2017.

FINDINGS OF FACT

Petitioner, Angela West, testified she began working for Respondent, Ford Motor Company, in September of 2010. (T 17). Petitioner began working as a floater performing various jobs and tasks. (T 17, 50) In January of 2011, Petitioner began to work in a permanent positon on the ignition panel line or IP line. (T. 50) At trial she described her job duties on the IP line as placing brackets into position and snapping them into place, guiding the ignition panel with her right hand and securing the ignition panel in the vehicle using an electric screw gun. (T20-22)

Petitioner testified she worked 40 hours a week and she would start work from 6:00 a.m. to 4:00 p.m. Petitioner testified that on April 1, 2011, she tripped over an ergo mat at work striking her right knee. (T27) On April 4, 2011, Petitioner went to the Ford Motor Company's Occupational Health clinic or "plant medical" for medical attention. (PX1, p. 14) Dr. Lewis examined Petitioner's right knee and found swelling and pre-patellar tenderness. Petitioner was diagnosed with a knee contusion. On April 1, 2011 Petitioner completed an accident report. On the report, Petitioner listed the date of accident or injury as April 1, 2011. When explaining how the accident occurred Petitioner wrote "tripped on floor matt, bruised knee". (PX1 p, 41)

After going back to work, Petitioner returned, again, to the company clinic complaining of numbness to her right foot. Petitioner refused to allow Dr. Lewis to palpate her right knee. Dr. Lewis noted Petitioner had full flexion and extension. X-rays of the knee was ordered. (PX 1, p. 14)

Later that day, Petitioner went to Ingalls Memorial Hospital and had X-rays taken. The x-rays showed no acute fractures or subluxations. No joint effusion was found and the articular surfaces were intact. (PX 2) The following day, April 5, 2011, Petitioner returned to the company clinic complaining of right knee pain. Petitioner was examined

by Dr. Lewis. Petitioner refused to fully flex and refused to allow Dr. Lewis to palpitate the knee. Petitioner placing her hands over her knee preventing Dr. Lewis from performing the test. Petitioner was returned to work. (PX 1, p. 16)

On April 12, 2011, Petitioner returned to the company clinic complaining of right knee pain. Dr. Lewis found no swelling or erythema. Petitioner complained of pain over the superior pole lateral aspect of the patella. Petitioner was returned to work and told to follow up with her personal physician. (PX 1, p. 19)

On April 6, 2011 and April 21, 2011, Petitioner sought treatment with Dr. Chand for her right knee. Petitioner reported falling at work striking her right patella. Dr. Chand examined Petitioner found effusion and tenderness over the patellofemoral areas. Dr. Chand ordered a MRI which showed a mild grade I medical collateral ligament sprain and mild-to-moderate joint effusion with 2.5 Backer cyst. X-rays showed mild degenerative changes in the knee joint including the patellofemoral area. (PX4, p. 8,9)

On November 29, 2011, Petitioner returned to Dr. Chand complaining of right knee pain from her fall back in April of 2011.

At trial, Petitioner did not testify to any current complaints regarding her right knee.

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998). An employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888 (2007).

The Arbitrator found the testimony of the Petitioner not to be credible.

WITH RESPECT TO ISSUE (C) WHETHER AN ACCIDENT OCCURRED THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

To obtain compensation under the Act, a claimant bears the burden of showing by a preponderance of the accidence, that the claimant has suffered a disabling injury which

arose out of and in the course of his employment. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 203, 797 N.E.2d 665, 671 (2003). In the course of employment refers to the time, place and circumstances surrounding the injury and, generally, must occur within the time and space boundaries of the employment. *Id.* An injury "arises out of" employment when "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." *Id* at 203, 797 N.E.2d at 672.

An employee who suffers a repetitive-trauma injury must meet the same standard of proof as an employee who suffers a sudden injury. *City of Springfield v. Illinois Workers' Compensation Comm'n*, 388 Ill.App.3d 297, 313, 901 N.E.2d 1066, 1079 (2009) The employee must allege and prove a single, definable accident that manifests itself on a specific date. *White v. Workers' Compensation Comm'n*, 374 Ill.App.3d 907, 873 N.E.2d 388, 391 (2007) (*quoting Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 530, 505 N.E.2d 1026, 1028 (1987)). The phase manifests itself signifies the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person. *Id.* Further there must be a showing that the injury is work related and not the result of a normal degenerative aging process. *Peoria County Belwood Nursing Home*, 115 Ill.2d at 530, 505 N.E.2d at 1028.

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proven by the preponderance of the credible evidence that Petitioner suffered an injury that arose out of and the course of her employment by Respondent on April 1, 2011 as set forth more fully below.

Petitioner testified that she fell on April 1, 2011 striking her right knee. On April 1, 2011, Petitioner completed a company accident report. On April 4, 2011, Petitioner went to the Ford Motor Company's occupational health clinic. Petitioner was examined by a company doctor who assessed a right knee contusion

The Arbitrator finds that on April 1, 2011, Petitioner sustained an accidental injury to her right knee which arose out of and in the course of her employment.

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

In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). Even though an employee has a preexisting condition which may make him more vulnerable to injury,

recovery for an accidental injury will not be denied if it can be shown that the employment was a causative factor. *Id.*

Petitioner testified she injured her right knee on April 1, 2011 and Petitioner completed and accident report. Petitioner sought treatment for her right knee from April 4, 2011 through November 29, 2011. Dr. Chand examined Petitioner found effusion and tenderness over the patellofemoral areas. Dr. Chand ordered a MRI which showed a mild grade I medical collateral ligament sprain and mild-to-moderate joint effusion with 2.5 Backer cyst. X-rays showed mild degenerative changes in the knee joint including the patellofemoral area. (PX4, p. 8,9)

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proved by the preponderance of the credible evidence that her right knee condition was causally related to her work injury of April 1, 2011.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTEND OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner sustained a grade I medical collateral ligament sprain and mild-to-moderate joint effusion with 2.5 Backer Cyst. Petitioner underwent treatment from April 1, 2011 through November 29, 2011. Petitioner's injury appears to have been painful such Petitioner did not allow the doctor to palpitate the patella. Petitioner was also diagnosed with a knee contusion. Petitioner complained of pain over the superior and lateral aspect of the patella.

Based on the above, and the Record, taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use of use of a right knee pursuant to §8(e) of the Act.

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

Isaias Garza,
Petitioner,

vs.

Tyson Foods, Inc.,
Respondent.

18IWCC0393

NO: 11 WC 14992

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, causal connection, medical, 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 April 11, 2017, is hereby affirmed and adopted.

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

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

The party commencing the 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 19 2018
o6/7/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0393

GARZA, ISAIAS
Employee/Petitioner

Case# **11WC014992**

TYSON FOODS INC
Employer/Respondent

On 4/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1367 HOPKINS & HUEBNER PC
PAUL SALABERT
100 E KIMBERLY RD SUITE 400
DAVENPORT, IA 52806

2593 GANAN & SHAPIRO PC
PAUL D DYKSTRA
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

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

ISAIAS GARZA,
Employee/Petitioner

v.

TYSON FOODS, INC.,
Employer/Respondent

Case # **11** WC **14992**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Rock Island**, on **3/9/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/10/10**, 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.

In the year preceding the injury, Petitioner earned **$28,318.07**; the average weekly wage was **$566.36**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his right shoulder due to repetitive work activities that arose out of and in the course of his employment by respondent, and manifested itself on 8/10/10. Petitioner's claim for compensation is denied.

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

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

Signature of Arbitrator

3/24/17
Date

APR 11 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 47 year old forklift driver, alleges he sustained an accidental injury to his right shoulder due to repetitive work activities that arose out of and in the course of his employment by respondent, and manifested itself on 8/10/10. Petitioner started working for respondent in 2000. In 2004 he started working as a forklift driver and worked as a forklift driver until 2010. Petitioner worked at least 8 hours a day. Petitioner's testimony was taken via an interpreter.

Petitioner testified that he has a 2nd grade education and only speaks a little English. He stated that he does not read English and only reads a little Spanish.

Petitioner testified that his duties as a forklift driver include driving and maneuvering containers of cow hides. The cow hides fall off a chain line and automatically drop into containers that are 5 feet tall. He testified that if there are too many cow hides falling into the containers he has to move, he picks them up off the floor and throws them on top of the container pile before maneuvering the container. He stated that the cow hides weigh about 100 pounds each. He testified that each container holds about 500 cow hides. Petitioner picks up and dumps the containers using a forklift. Petitioner moves about 40 containers a day.

Petitioner testified that he sits on the forklift and steers with his left arm and operates the levers with his right hand/arm. He stated that the levers are above shoulder level. However, when he demonstrated where the levers were his right arm was no higher than chest level. Petitioner is right hand dominant.

Petitioner presented to respondent's medical department at 7:05 pm on 8/10/10. He was seen by Nurse Sara Johnson. It was noted that the petitioner had presented with complaints of pain in his right anterior shoulder area. He related that he woke up Sunday and went to reach for a coffee cup in the cupboard and felt a pain in his shoulder area. He stated that it really bothered him when he had to shift the forklift into a certain gear. He rated his pain at a 4/10. Petitioner demonstrated full range of motion but felt pain with extension. Ice was applied to the area and he was given ibuprofen.

At trial, petitioner testified that he told Johnson that he had pain in his right shoulder when driving the forklift. He testified that the movement of the levers bothered his shoulder. He testified that no interpreter was present, but also testified that he did not ask for you. He stated that he communicated with the nurse in English. He testified that he been to the nurse's station previously for this problem and only got ice and pain pills. He testified that he told the nurse he could not handle the pain any more. He admitted that while making coffee at home he lifted the coffee with his right hand and it was hurting more. He testified that before he got his coffee

at home his right shoulder was very tired. He testified that his shoulder was hurting before he reached for the coffee.

On 8/10/10 a Non-Occupational Verification Form was completed for petitioner. The injury was described as "pain in R shoulder". It was noted that the injury was not work related. The first notice of the problems was identified as "Sunday morning". What he was doing when he first noticed the problem was identified as "making coffee in the am". With respect to where the injury occurred, it was noted as "felt first @ home". This form was filled out by Sara Johnson, LPN, at Tyson Medical Department. Petitioner signed the form, but testified that he did not know what he was signing and no one told him what he was signing. Petitioner testified that he could not read what was written on the form.

Petitioner returned to his full duty work and sought no further treatment until 10/10/10. He testified that he presented to the emergency room at that time because he could not stand the pain. Petitioner presented to Trinity Regional Health System Emergency Department. There are three different histories. First, he reported "right shoulder pain for 2 months, worse that evening" to the triage nurse. He denied any injury and rated his pain at a 8/10. Next, there was another note that petitioner "states has had R shoulder pain today worse (with) exercise/work, worse today". Lastly, he identified his onset/duration as approximately 2 weeks ago, and denied a recent injury. It was noted that "pet has had gradually worsening R shoulder pain for approximately 2 weeks. Did some (illegible) at home this weekend and now increased pain tonight". Where incident occurred was identified as "home". Petitioner's interaction at the emergency room was in English and he was given discharge instructions in English. No interpreter was used. He was discharged at 8:27 pm. X-rays of the right shoulder were taken and no acute findings were seen.

At trial, petitioner testified that he gave different histories at the emergency room on 10/10/10 because there was no one there to translate for him. However, he testified that he did not ask for an interpreter, because he did not think it was necessary. He testified that he only understood a very little of what the nurses and doctors told him. He claims he told the nurses and doctors about his job for respondent and that his right shoulder was bothering him. But then testified that he did not know what he told the nurses and doctors at the emergency room. He testified that he does not remember what he told them happened at home. He denied any accident at home. He testified that the problem he was seen for on 10/10/10 was the same problem he was seen for on 8/10/10.

On 10/11/10 petitioner also presented to Dr. Boardman at ORA for right shoulder pain that he claimed happened while working for respondent. He testified that his wife was with him and acted as his interpreter. Petitioner reported to have lateral shoulder pain that felt like a pulling movement. No known injury was noted.

He reported at least a 2 month history. He stated that the pain was worsened with exercising and twisting and relieved with pain medications. He rated his pain as 8/10 in severity. Following an examination Dr. Boardman's impression was right shoulder rotator cuff tendinitis. He recommended physical therapy for a month and injected the right shoulder with corticosteroid. At trial, petitioner testified that he did not know what he told Dr. Boardman at ORA.

On 10/12/10 petitioner presented to Rock Valley physical therapy. He reported that 2 months ago he started to develop right anterior lateral shoulder pain and ache. He stated that there was not one particular incident, but rather a gradual onset. He stated that his symptoms did not subside, but get worse. He reported increased pain and decreased mobility last weekend so he went to the emergency room. He reported that he works as a forklift driver in the hides department on the B shift. He reported that his job requires frequent to constant reaching and grasping of controls. He also reported that he periodically has to lift hides if they fall off lift.

On 10/19/10 petitioner was discharged from therapy. His current pain was 0/10. His disability/symptoms score was a zero. It was noted that petitioner's goals were met. Petitioner sought no further treatment until 2011.

On 3/15/11 petitioner returned to respondent's Medical Department and was seen by Annette Stucky, LPN. Petitioner presented with complaints of pain to his right anterior shoulder area. Petitioner related the pain to overreaching back in August while at home. He reported that he was seen by his PCP and was given steroid injections. He reported that he was better for a couple months and did not return to see his doctor. Petitioner reported that he began a course of physical therapy, but did not finish it. Petitioner also reported that he started to feel pain again in December 2010 and did not go back to see his PCP. He reported discomfort when shifting in the forklift. Petitioner was treated with ice, ibuprofen and biofreeze. He was released to full duty work. After Stucky spoke to Human Resources petitioner was sent home and instructed to see his PCP for his right shoulder pain. He was told he needed a medical release to return to work. He reported that physical therapy was completed.

On 3/23/11 petitioner returned to respondent's Medical Department with a medical note from ORA with restrictions of no lifting more than 5 pounds with his right arm. He was again seen by Stucky. He reported that his shoulder pain was recurrent and was related to the shoulder pain he was experiencing in October 2010. Petitioner reported shoulder pain in August of 2010 and related that the pain initially began in 2002 when he worked in the hide department and was trimming hides. Petitioner reported that his job was changed to forklift driver in hides and he continued to have right shoulder pain that he reported to his supervisor and was sent

respondent's Medical Department to be evaluated. Petitioner was unsure when he reported this to medical, but knows it was before August of 2010. Petitioner reported that he felt better after he had injections and did not go back to see the doctor for a follow-up visit. Petitioner reported that he did not finish physical therapy. He stated that he started to feel pain again in December and did not go back to the doctor or report it to Tyson's medical because the pain was minimal at that time. Petitioner gave a history of right shoulder pain again last week and related the pain to the injury back in August 2010. Petitioner wanted to report a workers' compensation claim because he felt that his pain was work related.

On 3/23/11 a Team Member Statement of Injury/Illness was completed. In response to where the injury happened, it was noted "at home in kitchen". In response to the job he was doing at the time of the injury, it was noted "reaching for a cup in cupboard". In response to how the injury happened, it was noted "reaching for a cup". It was noted that petitioner injured his right shoulder. It was also noted that he reported the injury before August to Debbie and Sara. In response to whether or not petitioner ever had injured this area before, it was noted that he had in 2002 and he was treated at the nurses' station. In response to whether or not anything could have been done to prevent this injury/pain/problem, it was noted "R shoulder should have been looked at by a doctor before". Petitioner signed this form. It was also signed by someone who read and interpreted this form to the team member. At trial, petitioner testified that he did not remember signing this form.

On 3/23/11 petitioner returned to Dr. Boardman. Petitioner reported temporary relief with physical therapy and a corticosteroid injection. He reported significant increased pain in the right shoulder that was worse with rotational and above shoulder height activity. Petitioner noted that it was similar in nature to that previously experienced in October. He noted that it was a recurrence of those symptoms. Dr. Boardman assessed recurrent right shoulder rotator cuff tendinitis. An MRI of the right shoulder was ordered. Dr. Boardman was of the opinion that this episode of symptomatology was related to what he experienced in October of 2010.

On 3/29/11 petitioner underwent an MRI of the right shoulder. The impression was degenerative change at the acrmioclavicular joint, without significantly inferiorly projecting osteophyte, and diffusely abnormal supraspinatus and infraspinatus tendons, with significant partial thickness tears of both tendons. No tendon retraction or muscular atrophy was noted.

On 4/6/11 petitioner returned to Dr. Boardman for review of the MRI of the right shoulder. Petitioner continued to report severe shoulder pain. He rated it at a 8/10. Dr. Boardman was of the opinion that the MRI of the right shoulder demonstrated a small full-thickness tear of the supraspinatus and some acromioclavicular joint osteoarthritic change. Dr. Boardman's impression was recurrent right shoulder pain secondary to rotator

cuff tear related to his work activities. He recommended a right shoulder arthroscopy, subacromial decompression, rotator cuff repair if necessary, and possible coracoplasty. Dr. Boardman was of the opinion that this surgery is associated with petitioner's work activities and his history would clearly bear this out in retrospective review. Petitioner was released to work with no lifting more than 5 pounds with the right arm. It was noted that at this visit the office visit was facilitated with the use of an interpreter.

On 4/18/11 petitioner's Application for Adjustment of Claim was filed. Petitioner alleged injuries to his right shoulder, right arm, neck, and body as a whole due to repetitive trauma that occurred on 8/10/10.

On 5/18/11 petitioner presented to Dr. Bringas, his PCP, at Genesis Health, with right shoulder problem. He reported 1-2 years of pain in the right shoulder. He reported pain radiating to the right side of the neck. This is the first mention of any neck problems in the record.

On 7/13/11 petitioner returned to Dr. Boardman with low back and right shoulder complaints that had been present for years, possibly related to his work activities. It was noted that the surgery was denied by workers' compensation. Dr. Boardman noted continued right shoulder impingement pain. Petitioner testified that his low back pain is not related to this claim. Dr. Boardman released petitioner on an as needed basis.

On 7/15/11 petitioner returned to Dr. Bringas for a recheck of his right shoulder. He reported that his right shoulder pain was persisting and severe. He reported that he was unable to raise his arm above his shoulder. He also reported severe tenderness, and weakness of the right shoulder. Petitioner's primary complaint this day was his low back. He was restricted from lifting, pushing and pulling.

On 8/29/11 petitioner underwent a preoperative evaluation for his right shoulder. On 8/30/11 petitioner underwent a right shoulder rotator cuff repair, biceps tenodesis, and subacromial decompression. This procedure was performed by Dr. Boardman. Petitioner's post-operative diagnosis was right shoulder supraspinatus rotator cuff tear and biceps tendon tear. Petitioner followed-up post-operatively with Dr. Boardman. This treatment included a course of physical therapy at Rock Valley physical therapy. He also periodically returned to Dr. Bingas.

On 9/12/11 petitioner presented for his Initial Evaluation at Rock Valley physical therapy. He stated that sometime in August of 2010 he developed right anterior lateral shoulder pain. He stated that there was not one particular event. He stated that after some treatment he was returned to full duty work and in March 2011 his symptoms returned, only worse. The onset was insidious.

On 9/19/11 petitioner reported to his therapist that he slipped on the steps and fell onto his right shoulder and hip. He reported a significant amount of increased shoulder pain and "pressure" in the anterior shoulder region. The therapist was of the opinion that the recent fall provided no residual issues.

On 10/31/11 Dr. Boardman released petitioner to work with no lifting greater than 10 pounds with his right upper extremity. He was allowed to drive a fork lift. Petitioner did not return to Dr. Boardman after this visit.

On 1/11/12 petitioner was discharged from physical therapy. It was noted that petitioner had progressed well with therapy, and was independent with his home exercise program. It was noted that if petitioner remained diligent with this program, anticipated resolution of minor cuff weakness would be achieved independently.

When petitioner last presented to Dr. Bingas on 8/15/12 he reported that some days his right shoulder feels good and other days he has pain depending on exercise. He reported that his shoulder was getting better and he was almost recovered 90%.

Petitioner testified that he returned to his full duty job and is doing the same job he was doing on the alleged date of accident. Petitioner denied any trauma to his right shoulder prior to 8/10/10.

On 6/17/14 the evidence deposition of Sara Johnson, LPN, was taken on behalf of respondent. Johnson testified that she was working as an LPN for respondent on 8/10/10. She stated that she worked in respondent's health service department and took care of employee injuries. She testified that petitioner came into the health service department on 8/10/10. She testified that she completed the Non-Occupational Verification with the employee. She stated that this form is for non-work related injuries and a different form is used for work injuries. She stated that she writes down on the form what the employee tells her. After reviewing the note, she stated that she remembered the incident. She testified that petitioner reported to her that he was having pain in his right shoulder and she asked him how he hurt it. She testified that petitioner told her that the first time he felt pain was when he was reaching for a cup of coffee in the cupboard when he was at home. Johnson testified that she helped petitioner fill out the form. She asked him the questions and he told her the answers. She then wrote down the answers for him and they both signed the form. Johnson denied that petitioner ever told her he injured his right shoulder at work.

On cross-examination, Johnson stated that petitioner, who was present during her deposition, looked familiar, but she had no recollection of him. She testified that she did not think an interpreter was present, because if one was needed, she would have noted that there was an interpreter present. She testified that she

always notes that there is an interpreter, if one is present. She testified that she believed petitioner was able to speak enough English and understand it to answer the questions. Johnson testified that she examined petitioner, but did not diagnose him. She give petitioner ice and ibuprofen, and instructions on how to reduce the pain.

Petitioner testified that he feels his alleged injury to his right shoulder is due to his repetitive work for respondent where he drives his forklift, lifts cow hides and fills up containers. Currently, petitioner works in a different department, but did not provide the specific details of this job. He testified that when he drives a lot at work he has some right shoulder pain and it feels tired.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner is alleging an injury to his right shoulder due to repetitive work activities, that arose out of and in the course of his employment by respondent, and manifested itself on 8/10/10.

As a general rule, repetitive trauma cases are compensable as accidental injuries under the Illinois Worker's Compensation Act. In Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 111.2d 524, 106 Ill.Dec 235, 505 N.E.2d 1026, the Supreme Court held that "the purpose behind the Workers' Compensation Act is best serviced by allowing compensation in a case … where an injury has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction.." However, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

Since petitioner is claiming injuries to his right shoulder, in Illinois, recovery under the Workers' Compensation Act is allowed, even though the injury is not traceable to a specific traumatic event, where the performance of the employee's work involves constant or repetitive activity that *gradually* causes deterioration of or injury to a body part, assuming it can be medically established that the origin of the injury was the repetitive stressful activity. In any particular case, there could be more than one date on which the injury "manifested itself".

Petitioner is alleging a manifestation date of 8/10/10. On this date petitioner reported to respondent's medical department with complaints of pain in his right anterior shoulder area. The history noted at that time was that when he reached for a coffee cup in the cupboard on Sunday he felt pain in his shoulder area. He also stated that it bothered him when he had to shift the forklift into a certain gear. It was noted that the injury was not work related.

Petitioner testified that he cannot read English and only speaks a little English. Both he and Johnson stated that no interpreter was present. Johnson testified that she communicated with petitioner in English and wrote down everything he said. Although he signed the Non-Occupational Verification form, petitioner testified that he did not know what he was signing and could not read what Johnson wrote. Petitioner admitted that he never asked for an interpreter.

Following this visit petitioner returned to his regular duty job and did not seek any further treatment until he presented to the emergency room on 10/10/10. Three different histories were provided. The first was that he had pain in his right shoulder for the past 2 months. The second history was right shoulder pain that was worse that day with exercise/work. The third history was onset of pain 2 weeks ago while doing something at home that weekend, with increased pain now. The place where the injury occurred was noted as his home. Petitioner's interaction with the staff at the emergency room was in English. Petitioner did not ask for an interpreter. He testified that he did not think it was necessary.

The next day he presented to Dr. Boardman with right shoulder pain that happened while working for respondent. He reported a 2 month history of pain. Petitioner did not provide Dr. Boardman with a description of his work activities. At Physical Therapy on 10/12/10 petitioner again reported right shoulder pain for 2 months. He reported that his job requires frequent to constant reaching and grasping of controls and periodic lifting of hides. On 10/19/10 petitioner was discharged from physical therapy. His rated his pain at 0/10 and his disability/symptoms score was zero.

Petitioner sought no further treatment until he returned to respondent's Medical Department on 3/15/11 with complaints of right shoulder pain. He related the pain to overreaching back in August while at home. He also reported discomfort when shifting in the forklift.

On 3/23/11 he returned to the respondent's Medical Department with recurrent shoulder pain last week related to the shoulder pain he was experiencing in October 2010. It was also noted that petitioner reported shoulder pain in August of 2010 that initially began in 2002 while working in the hide department and trimming hides.

That same day a Team Member Statement of Injury/Illness was completed. In response to where the injury happened, it was noted "at home in kitchen". In response to the job he was doing at the time of the injury, it was noted "reaching for a cup in cupboard". In response to how the injury happened, it was noted "reaching for a cup". It was noted that petitioner injured his right shoulder. It was also noted that he reported the injury before August to Debbie and Sara. In response to whether or not he had ever injured this area before, it was noted that

he had in 2002 and he was treated at the nurses' station. In response to whether or not anything could have been done to prevent this injury/pain/problem, it was noted that "R shoulder should have been looked at by a doctor before". Petitioner signed this form. It was also signed by someone who read and interpreted this form to him. The arbitrator finds this significant because petitioner testified that he never knew what he was signing. Here, it is clear that what was written on this form was interpreted for him.

An MRI of the right shoulder was performed on 4/6/11and Dr. Boardman recommended surgery for petitioner's right shoulder. It was about 12 days after this that petitioner filed his Application for Adjustment of Claim alleging injuries to his right shoulder, right arm, neck and body due to repetitive trauma that occurred on 8/10/10.

Given that the burden of proof is on the petitioner to prove by a preponderance of the credible evidence that he sustained an accidental injury to his right shoulder due to repetitive work activities that arose out of and in the course of his employment and manifested itself on 8/10/10, the courts have held that in order to prove a repetitive trauma injury related to work activities it is imperative that the claimant place into evidence specific and detailed information concerning his work activities, including the frequency, duration, manner of performing, etc. In the case at bar, the arbitrator finds the petitioner has failed to place this information into evidence. Other than claiming that he is a forklift operator that drives and maneuvers containers of cow hides an on occasion has to lift cow hides weighing 100 pounds that do not fall of the chain into the containers, the petitioner failed to provide the frequency, duration, and manner in which he performed these activities. Although petitioner reported pain when he shifted the forklift into certain gears, he did not indicate which gears he was referring to and how often he performed this activity. He also testified that the levers he shifts are above shoulder level. However, when he demonstrated this activity for the court his right arm was no higher than chest level. The arbitrator also notes that in an 8+ hour day petitioner testified that he moved about 40 containers, which is only about 5 an hour. Petitioner provided no details as to what maneuvering of the forklift is needed to perform this activity and exactly where these containers are moved. With respect to the lifting of the cow hides when they fell out of the container, the only specifics he provided were that they weighed about 100 pounds each, and he only did this occasionally. The actual frequency and manner in which he performed this activity was not provided. Petitioner also failed to offer into evidence any job description that detailed the specifics of his job duties. Lastly, the arbitrator finds it significant that the problems with his right shoulder actually began in 2002 when he was working in the hide department trimming hides. Again, petitioner failed to provide any specific and detailed information concerning these work activities.

When proving up a repetitive trauma claim, in addition to placing into evidence specific and detailed information concerning your work activities, including the frequency, duration, manner of performing, etc., it is also equally important that the medical experts have a detailed and accurate understanding of the claimant's work activities. Petitioner reported to the medical department that his right shoulder bothered him when he had to shift the forklift into a certain gear. He also reported pain in his right shoulder when driving the forklift and moving the levers. He reported to Dr. Boardman pain in his right shoulder while working for respondent. Based on this history, Dr. Boardman was of the opinion that the surgery he was recommending for petitioner was associated with his work activities. However, given the fact that there is no credible evidence to support a finding that Dr. Boardman had a detailed and accurate understanding of the petitioner's work activities, the arbitrator gives little weight to his opinion.

In addition to petitioner not providing, and the medical experts not having, a detailed and accurate understanding of his work activities the arbitrator finds the petitioner has failed to prove by preponderance of the credible evidence that he sustained an accidental injury to his right shoulder due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 8/10/10. The arbitrator also bases this finding on the fact that on numerous occasions, including his visits to respondent's Medical Department on 8/10/10, 10/10/10, 3/15/11, and 3/23/11 petitioner consistently provided no history of an accident due to repetitive work activities, but rather to incidents that occurred at home on or about 8/10/10, at the end of September 2010, or the beginning of October 2010.

Petitioner made reference to his right shoulder problems beginning while at home. Although petitioner testified that many of these references were because he did not have an interpreter present and could not communicate very well with the medical experts, and could not read what they had him sign, the arbitrator finds this is clearly not the case with respect to the history provided on 3/23/11 when he signed a Team Member Statement of Injury/Illness indicating that the injury happened at home in the kitchen while reaching for a cup in the cupboard before August. The arbitrator notes that in addition to petitioner signing this form, the form was also signed by someone who read and interpreted this form to petitioner. The arbitrator finds this disproves petitioner's claims that he never had an interpreter present. The arbitrator also finds this significant given the fact that the information petitioner provided via an interpreter on 3/23/11 regarding the onset of his right shoulder problems was the same as the information he provided on the instances in which he did not have an interpreter and did not understand what the health care providers were asking or saying. The arbitrator finds this shows petitioner was communicating better with the health care providers than he lead the court to believe.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his right shoulder, due to repetitive work activities, that arose out of and in the course of his employment by respondent and manifested itself on 8/10/10.

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?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his right shoulder due to repetitive work activities that arose out of and in the course of his employment by respondent, and manifested itself on 8/10/10, the arbitrator finds these remaining issues moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Darby,

18IWCC0394

Petitioner,

vs. NO: 12 WC 41148

Kraft Foods,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical, causal connection and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

As indicated above, this matter was arbitrated under §19(b) of the Act. The Arbitrator found that Petitioner failed to meet his burden of proving a compensable accident. The Commission affirms that finding. However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." Because the claim was denied in its entirety, the matter will not be remanded for determination of any additional benefits and therefore the decision does bar subsequent awards. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator.

18IWCC0394

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 1, 2017, is hereby affirmed and adopted with the changes noted above.

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 19 2018
o6/7/18
DLS/rm
46

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

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

18IWCC0394

DARBY, DANIEL
Employee/Petitioner

Case# **12WC041148**

KRAFT FOODS
Employer/Respondent

On 11/1/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.26% 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:

2412 BEATTY & MOTIL
ADAM W BRAGEE
78 S MAIN ST PO BOX 730
GLEN CARBON, IL 62034

1109 GAROFALO SCHREIBER STORM
JAMES R CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

18IWCC0394

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)

DANIEL DARBY
Employee/Petitioner

v.

KRAFT FOODS
Employer/Respondent

Case # 12 WC 41148

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **May 23, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **October 8, 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.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment on October 8, 2012. All benefits are hereby denied. All other issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

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

Signature of Arbitrator

October 29, 2017
Date

ICArbDec19(b)

NOV 1 - 2017

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

DANIEL DARBY
Employee/Petitioner

v.

Case #: 12 WC 41148

KRAFT FOODS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On October 8, 2012, Petitioner was 58 years old, married, with no dependent children. He testified he worked for Respondent from 1986 until his retirement in December 2016. He worked a short time as a machine operator, but primarily worked as a palletizer operator. He operated four palletizers, which were machines to place products onto pallets and prepare them for delivery. His job duties included accepting all of the pallets and making sure the cases were stacked properly on the pallets, which were then delivered to the trucks for delivery. If product fell off the pallet or a pallet fell off the conveyor, Petitioner would correct the problem by lifting the product or the pallet back into place. If a palletizer became jammed he would correct that as well. Some of these corrections would be done with the aid of a crowbar. Petitioner testified that he moved 40 to 50 pallets in a shift, each weighing 50 to 60 pounds.

Petitioner testified that on the date of the accident he was unjamming a pallet with a crowbar and while twisting the pallet straight and putting the product back on the pallet, he twisted and his back popped. He felt immediate pain in his lower back and he went down to his knees for a few seconds. He eased himself up and co-workers helped him finish putting the palletizer together. He testified that the next morning he reported the accident to his shift lead, Mr. Jeremy Holtgrave, and that eventually he also spoke with supervisor Mike Stevens. He continued working for the following week and testified that co-workers Steve Kromroy and Ron Cooper assisted him. Petitioner testified that prior to this accident he had never taken any time off work due to back pain.

Petitioner testified he saw Dr. Charles King, who took him off work. Dr. King provided physical therapy and chiropractic adjustments, which helped somewhat but did not resolve his pain. Dr. King referred him to Dr. Kennedy in March 2013, who, to Petitioner's understanding, diagnosed spondylolisthesis and prescribed hydrocodone, muscle relaxers, and sleeping pills.

Dr. Kennedy eventually performed surgery on June 15, 2015, which consisted of decompression and screws and a plate. The surgery was paid by his group health insurance, as worker's compensation would not cover it. Petitioner testified he got relief from the surgery for about eight months, and then his pain gradually came back. He continues to have pain and trouble with lifting, bending, helping around the house, and the like. Dr. Kennedy has recommended a second surgery, which Petitioner would like to have.

On cross-examination, Petitioner confirmed that the first surgery was paid by the group coverage provided by Respondent. Petitioner acknowledged that he had a previous lumbar MRI on March 5, 2012, and that he had previous lumbar x-rays in September 2011.

Following the accident, Petitioner treated with chiropractor Charles King beginning November 13, 2012, approximately five weeks later. The Arbitrator notes that Dr. King's treatment records were not proffered at the time of the hearing. However, Dr. King testified by way of deposition on October 8, 2014. PX4.

Dr. King testified that Petitioner presented to his office on November 13, 2012, upon referral by his attorney. He reported that on October 8, 2012, he was bent over a pallet at work when he noticed sudden pain and had a popping sensation in his back. He had seen his family physician but had continued pain and sought further treatment options with chiropractic care. He reported pain in his lower back and radiating symptoms to his lower extremities. On examination, he had palpable spasm to the lumbar region, reduced range of motion, and positive straight leg raise. X-rays showed degenerative joint disease with a pre-existing vacuum effect and spondylolisthesis at L5-S1. Impression was strain/sprain of the lumbar spine superimposed upon degenerative joint disease and instability. Dr. King opined that Petitioner's accident caused the sprain/strain and aggravated his pre-existing conditions and testified that his treatment of Petitioner was reasonable, necessary, and causally related to the incident at work on October 8, 2012. He testified Petitioner began treatment, including physical therapy at his office, which continued through January 30, 2013, and that he had seen Petitioner periodically since that time. PX4.

During his deposition, Dr. King's treatment records for Petitioner were identified, marked as Petitioner's Exhibit 3, and admitted. However, the records were not attached to the deposition transcript admitted at trial and as such are not available for the Arbitrator's review or consideration. Dr. King testified he last saw Petitioner on October 1, 2014, and that his condition had continued to deteriorate, as had his ability to tolerate routine activities. PX4.

Dr. King was asked about a physical therapy evaluation note dated November 15, 2012, two days after his initial examination of Petitioner. The evaluation was conducted by a therapist in his office. He read into the record a portion of the evaluation note:

"He had back pain off and on for a while, but his back started getting worse after he injured his back on 10/8/12. He was picking up cases of juice at work, approximately 10 pounds, inside a small space, where he was twisting and turning, trying to get them on a pallet, and he heard his back pop. He felt immediate sharp pain that progressively got worse after. He put heat on his back, had his wife massage his back to wait out a week. He reported it to work because he was still having pain and followed up with his primary care physician. He, in turn,

sent him to a back specialist who did nerve tests on him. The nerve tests showed that both feet were affected, and he had arthritis in his back. The back specialist set him up with therapy. In the meantime, he spoke with his attorney (you), who referred him to (me), and x-rays were taken by this office showing degenerative changes and the spondylolisthesis." PX4.

Dr. King testified that he eventually referred Petitioner to Dr. David Kennedy, due to the MRI results and Petitioner's examination findings. With regard to the surgery proposed by Dr. Kennedy at that time, Dr. King opined that the surgery was necessary due to Petitioner's work accident, despite Petitioner's longstanding back problems prior to October 8, 2012. He did note, however, that he "didn't have the luxury of examining him prior". PX4.

On cross-examination, Dr. King testified that the underlying condition identified on the MRI of January 29, 2013, was stenosis of the disc space, which takes time to develop, and bulging annulus at L4-5. He acknowledged that the MRI cannot tell you when the stenosis first developed, and agreed it could have predated October 8, 2012, and could advance over time by itself without any trauma. He also acknowledged that the bulging disc at L4-5 was not uncommon for someone of Petitioner's age of 58. He opined that the subsequent MRI of August 14, 2014, showed Petitioner's conditions had advanced, but admitted that he had not viewed the films himself, and that the films were read by two different radiologists. PX4.

Continuing on cross-examination, Dr. King confirmed that Petitioner was referred to him by his attorney. He testified that histories were important, as they gave a background of the patient's mechanism of injury, past history of back problems, and treatment to date. He agreed that, seeing Petitioner 35 days after October 8, 2012, he could not say the reduced flexion was the result of the work accident, other than the fact that Petitioner told him the accident occurred and that the finding was a reasonable one for what he said occurred. Dr. King could not say that the findings he made on November 13, 2012, did not predate October 8, as he did not see Petitioner prior to that time. PX4.

Dr. King testified his understanding was that Petitioner saw Dr. Burger and Dr. Morgan after his work accident. He did not review medical records from either physician. He also did not review any records prior to October 8, 2012, nor was he aware of Petitioner's last treatment for back problems prior to that date. He understood that Petitioner had undergone a previous MRI before the work incident. He admitted it could be helpful to know the findings of that MRI, as well as prior treating records, to determine what extent, if any, the work incident had on his pre-existing conditions and to thus give a more accurate opinion as to causal connection. PX4.

Dr. King acknowledged that Petitioner gave him a very specific history of what he was doing at work on October 8, and that he experienced a pop and sudden pain at that time. He agreed that was a description of a traumatic incident which someone should remember. He admitted he was unaware that Dr. Burger was a neurologist and that Petitioner had seen him on October 16, 2012, eight days after the alleged incident on October 8, 2012. He was further unaware that Petitioner gave Dr. Burger a history of a longstanding history of low back pain radiating down both legs, which was worse over the past six months. He agreed that would date Petitioner's symptoms back to sometime in April or May of 2012. He had no explanation for why Petitioner did not tell Dr. Burger about the incident at work on October 8, 2012. PX4.

On February 20, 2013, Petitioner was evaluated by Dr. Robert Bernardi, Respondent's Section 12 examiner. He reported he had had prior episodes of back pain which had been intermittent, had never lasted more than a day, and had never caused him to miss work. He did admit that he had previously seen his family physician about the problem and had been prescribed Ultram. RX1, Dep.RX2.

With regard to the incident on October 8, 2012, Petitioner advised Dr. Bernardi that he was bent forward at the waist picking up cases of product that had fallen on the floor. He was stacking them on a pallet when he felt and heard a pop in his low back, followed by immediate pain. He stated he felt like the strength went out of his legs, and he sat down and rested for a few minutes. He then finished stacking the pallet and restarted the machine. He sat for the rest of the day and co-workers helped him with any physically demanding tasks. He waited to see if his symptoms would improve, but two days later they became more intense. When symptoms continued after a week, he made an appointment with his family physician, Dr. Morgan, and reported the incident to his employer. RX1, Dep.RX2.

Petitioner advised Dr. Bernardi that Dr. Morgan referred him to neurologist Dr. Burger and to pain management physician Dr. Anderson. Dr. Burger performed an EMG/NCS and secured a lumbar MRI. He further advised he had been seen at Gateway Occupational Health Services and by a chiropractor. RX1, Dep.RX2.

Dr. Bernardi reviewed and summarized records from chiropractor Charles King, including physical therapy notes, as well as records from Gateway Occupational Health Services (Gateway) and the lumbar MRI of January 29, 2013. With regard to Gateway, Petitioner was first seen on December 18, 2012, by Dr. Christopher Knapp. It was noted he had not reported his symptoms immediately after the accident. He had already had one epidural injection by Dr. Anderson. Dr. Bernardi noted, "Dr. Knapp implies that Mr. Darby already had an appointment to see Dr. Morgan for his chronic back symptoms at the time of his injury. Prior to that injury, these symptoms had already been worked up with an MRI and x-rays." Dr. Knapp recommended work restrictions, prescribed Relafen, and refilled Ultram. Petitioner returned to Dr. Knapp on December 26, 2012, and reported he was about 70% better. He was scheduled for another injection the next day. Petitioner returned to Dr. Knapp again on January 2, 2013, and was slowly improving. He reported the injections had helped and he was still going to therapy in Dr. King's office. Prescriptions were refilled and work restrictions continued. He was scheduled for a third epidural injection on January 18. RX1, Dep.RX2. The Arbitrator notes that records from Gateway were not proffered at the time of hearing.

On examination, Dr. Bernardi did not detect any trigger points but did not that the lower lumbar paraspinal muscles were palpably taut. There was pain to palpation in the gluteal muscles behind the left greater trochanter, tenderness along both iliotibial bands, and pain with palpation around the right sciatic notch. Straight leg raise was negative and range of motion was painful. Strength was normal and there was no atrophy. RX1, Dep.RX2.

Dr. Bernardi provided five diagnoses for Petitioner: (1) multilevel degenerative disc/facet disease; (2) L5-S1 isthmic spondylolisthesis; (3) multilevel spinal stenosis; (4) low

back pain; and (5) bilateral leg pain of uncertain etiology. He opined that the MRI did not show any acute abnormalities and that none of the findings on the study were caused by his work accident on October 8, 2012. With regard to whether the accident aggravated a pre-existing condition, Dr. Bernardi advised he was unable to answer that question with the information currently available to him. He noted that Petitioner reported prior bouts of back pain that never lasted more than a day, yet he also reported that his family physician had previously prescribed Ultram for his symptoms. He stated, "I am not clear why that would have been necessary for symptoms that only lasted 24 hours." Dr. Bernardi further noted that the records suggested Petitioner had these symptoms evaluated with plain x-rays and an MRI before his work injury in October 2012. He stated, "Again, if his previous back symptoms had been as minor as suggested to me, I am not certain why that would have been necessary." Finally, he noted that Dr. Knapp's note of December 18, 2012, suggested that Petitioner already had an appointment scheduled with his family physician for chronic back symptoms before the work accident occurred. Dr. Bernardi requested additional information with regard to these questions, in order to determine whether Petitioner's work accident aggravated his pre-existing back condition. RX1, Dep.RX2.

On March 6, 2013, Petitioner presented to neurosurgeon Dr. David Kennedy, upon referral by Dr. King. He reported that on October 8, 2012, he was moving pallets that were stuck and was bent over using a crowbar when he felt a pop in his lower lumbar area and immediately had pain. Dr. Kennedy noted, "He states that he has not had any prior problems with his lower lumbar area." He noted Petitioner had undergone four injections, which did not offer relief. On examination, range of motion was significantly reduced and straight leg raise was positive bilaterally. Dr. Kennedy reviewed the lumbar MRI of January 29, 2013, which showed spondylolisthesis at L5-S1 with significant bilateral foraminal encroachment. He opined that rhizolysis, which had been recommended, had a low probability of providing relief, and that he would need lumbar decompression and fusion at L5-S1. He opined that, based on the available information, Petitoner's symptoms and need for treatment was related to the work accident of October 8, 2012. PX1.

Petitioner returned to Dr. Kennedy on April 16, 2012, and July 30, 2012. Complaints and examination findings remained unchanged and a myelogram was recommended at both visits. On August 14, 2013, Petitioner underwent a myelogram and CT, which revealed: (1) Grade II anterolisthesis L5 on S1 with bilateral pars defects at L5; (2) severe bilateral foraminal narrowing L5-S1 and mild to moderate bilateral foraminal narrowing L4-5; and (3) mild canal stenosis L4 through S1. PX1.

Petitioner returned to Dr. Kennedy's office on November 18, 2013, and was examined by Nurse Practitioner Sejal Patel. He reported constant left foot numbness with prolonged sitting, pain rated at 10/10, and increased right hip pain. He noted he was having carpal tunnel surgery the following day. On exam, he had positive straight leg raise on the right. NP Patel noted they were waiting for authorization for posterior lumbar fusion L4-S1. PX1.

On December 30, 2013, Petitioner followed up with NP Patel. He reported he had recently had carpal tunnel surgery, fluid aspirated from his left knee, and an allergic reaction to one of his gout medications. With regard to his low back, he reported continued pain rated at 6/10 and an increased amount of pressure in his tailbone area. On exam, he had positive straight

leg raise on the right and reduced range of motion overall. NP Patel noted they were continuing to await authorization for surgery. PX1.

On February 8, 2014, Dr. Bernardi authored an Addendum IME report after reviewing additional records and a surveillance video. Of note, Dr. Bernardi reviewed an MRI scan done on March 15, 2012, ***seven months before*** Petitoner's alleged work accident. The MRI report stated it had been done for complaints of back pain, and further that results were compared to lumbar x-rays done on September 8, 2011. The MRI showed L5-S1 isthmic spondylolisthesis with severe bilateral L5 foraminal narrowing, and L4-5 degenerative disc and facet disease with central and lateral recess stenosis and right L4 foraminal compromise. Also of note, Dr. Bernardi reviewed a report from Dr. Stephen Burger of October 16, 2012, ***eight days after*** Petitioner's alleged accident. The report noted Petitioner had "a long-standing history of low back pain radiating down both legs, worse over the past six months". Dr. Berardi pointed out that there was no mention of a work accident, and further pointed out that Dr. Burger noted that he wanted to review Petitioner's "recent MRI". Dr. Bernardi also reviewed records from Dr. Anderson, which contained an accident history similar to what Petitioner reported to him. Other records included those from his family physician and Dr. Kennedy. Per the stipulation of the parties, the Arbitrator disregarded any reference, summary, or impression with respect to surveillance video. RX1, Dep.RX3.

Dr. Bernardi opined that, although review of additional earlier records would be helpful, it was increasingly difficult to attribute his back and leg symptoms to his work activities on October 8, 2012. He emphasized that Petitioner saw Dr. Burger on October 16, 2012, only eight days after his alleged accident, and yet made no mention of the accident. Instead, he reported long-standing back pain that had been worse over the previous six months, which was corroborated by the fact than an MRI was done in March 2012. Dr. Bernardi noted that although Petitioner reported a prior history of back pain, he also reported the episodes were mild and never lasted more than a day. He stated, "I find that difficult to accept. Mild, short-lived pain should not require the use of prescription analgesics. Likewise, it is difficult to imagine why it would require evaluation with plain films and an MRI. The scanty records available to me suggest that Mr. Darby has a chronic history of low back pain stretching back for at least a year prior to his alleged work injury." RX1, Dep.RX3.

Dr. Bernardi pointed out that Petitoner's pre-injury MRI of March 15, 2012, was in all ways identical to his post-injury MRI of January 29, 2013. He believed the spondylolisthesis was responsible for Petitoner's complaints, as it is a well-known cause of chronic back and leg pain. He opined that none of the findings in Petitoner's low back were acute or post-traumatic and none could be attributed to his alleged work accident. He noted that Petitioner was alleging that an unwitnessed lifting accident at work aggravated an already-aggravated pre-existing condition. Dr. Bernardi stated, "It goes without saying that this allegation is entirely subjective." With regard to treatment for Petitoner's condition, Dr. Bernardi opined that he did have a structural anomaly that was most likely the cause of his symptoms and which was amenable to surgery. However, he cautioned that success rate in the general population was 70-80% and in the worker's compensation population it was only 40%. Finally, he opined that if Petitioner elected to have surgery, he was unable to causally relate the need for surgery to his alleged work accident on October 8, 2012. RX1, Dep.RX3.

Dr. Bernardi testified by way of deposition on October 10, 2014. He is a Board Certified Neurosurgeon. He testified consistent with his two reports, detailed above. On cross-examination, he acknowledged that he was not aware of how much the pallets weighed that Petitioner moved as part of his job duties. He conceded that lifting the pallets could aggravate pre-existing conditions, but also noted that moving something much lighter than that could also aggravate a pre-existing problem. In addition, he testified that the duration of Petitioner's complaints disturbed him. He acknowledged that Petitioner reported to Dr. Anderson a history of accident very similar to that which he reported to Dr. Bernardi, but noted that occurred in November 2012. On re-direct examination, Dr. Bernardi testified that, although Petitioner related his pain, need for work restrictions, and need for medical care and surgery to an alleged accident on October 8, 2012, Dr. Burger's report of October 16, 2012, argues to the contrary. He explained that Dr. Burger's report noted Petitioner had been experiencing chronic back and bilateral leg pain that had been worse for the previous six months. Further, Petitioner's claimed minor and short-lived prior pain would not have warranted a lumbar MRI, lumbar x-rays, and prescription medications. RX1.

Throughout 2014, Petitioner was seen by NP Patel or Dr. Kennedy on February 11, March 24, May 6, June 16, July 28, September 11, October 22, and December 4. Complaints and examination findings remained the same. Petitioner was seen by NP Patel on February 9, 2015, and by Dr. Kennedy on April 14, 2015. He reported that his pain was becoming progressively more severe. PX1.

On June 15, 2015, Petitioner underwent surgery by Dr. Kennedy, which consisted of decompression and fusion of levels L4 through S1. He followed up with NP Patel on August 5, 2015, and reported a couple instances of increased pain from twisting and attempting to ride his lawn mower. He saw Dr. Kennedy on September 15, 2015, at which time range of motion was still reduced by 50%, but straight leg raise was negative and strength was intact. He was to start physical therapy with Dr. King. He returned to Dr. Kennedy on November 17, 2015, and reported he was doing well with no leg pain and only minimal stiffness in the lower lumbar area. Lumbar x-rays showed stable postoperative changes. PX1.

On January 13, 2016, Petitioner returned to NP Patel and denied any back pain or leg pain at that time. Lumbar x-rays showed persistent S1 lucency. It was noted he was doing well in physical therapy and would transition to a home exercise regimen. Petitioner followed up with Dr. Kennedy on March 22, 2016, and reported he was generally better. It was noted he had recently had reconstructive right knee surgery and had pain and swelling in that area. Lumbar x-rays showed progression of the fusion. He followed up on May 4, 2016, and reported worsening low back pain, especially in the afternoon or as the day progresses, and especially after he has been active all day. It was noted he continued to have swelling from his right knee surgery. It was further noted he had ongoing right groin pain which produced left back pain and focal tenderness of his left paraspinous area. X-rays showed persistent lucency surrounding the left L5 screw, but instrumentation was intact. PX1.

On August 10, 2016, Petitioner underwent a lumbar CT scan, which showed (1) osseous fusion not present posterolaterally at L4-5 or L5-S1; (2) left L5 pedicle screw directed caudally, along the superior margin of left L5-S1 neural foramen; and (3) multilevel degeneration. PX1.

The next treatment record is April 5, 2017, when Petitioner returned to NP Patel. He reported bilateral lower extremity pain radiating down his buttock to his calf, primarily on the left, and noted his symptoms were gradually worsening. He reported hearing a pop and click in his lower back when trying to stand straight. He also reported numbness and tingling on both feet, left greater than right. He denied spasms but reported some weakness and difficulty getting out of bed. On examination, range of motion was reduced but he was able to heel/toe and walk without significant issues. Strength was intact. NP Patel recommended ongoing pain management of possibly injections or medications. He noted, "As previously recommended by Dr. Kennedy, we recommend L4-S1 hardware removal and revision of the same levels with re-instrumentation." The Arbitrator notes there was no prior reference to such surgery in the records admitted and detailed above. Petitioner was instructed to follow up with Dr. Kennedy on July 13, 2017. PX1. The Arbitrator notes this is the final treatment record.

Dr. Kennedy testified by way of deposition on June 2, 2015. He is a Board Certified Neurosurgeon. Dr. Kennedy testified consistent with his treating records. PX3.

Dr. Kennedy noted that in conjunction with Petitioner's first examination on March 6, 2013, he completed a Medical History, on which he noted he had history of arthritis and back trouble. He testified that the spondylolisthesis and significant foraminal encroachment at L5-S1, as shown on the MRI of January 29, 2013, predated Petitioner's accident of October 8, 2012, but that the accident aggravated those pre-existing conditions. He provided further details by testifying, *"Well by his description, he was straining pretty hard with the crowbar, and I think that that type of extreme flexion with...a good deal of pressure being put on the back by virtue of that can certainly convert a radiographic finding such as he'd exhibited into a significantly symptomatic problem."* He testified that Petitioner needed the lumbar decompression and fusion at L5-S1 to remove the pressure that was impacting the nerve roots and to provide stability so as to eliminate abnormal movement. PX3.

On cross-examination, Dr. Kennedy acknowledged that a Workers' Compensation Patient Information Form was contained within his physical file. He further acknowledged that the form had been completed and signed by Petitioner and did not indicate anything about a crowbar. He testified that Petitioner had been referred to him by Dr. King, but that he did not have any records from Dr. King. He was read the accident history contained within Dr. King's record, as well as Dr. King's testimony, which indicated that Petitioner stated he was bending over a pallet and noticed sudden pain in his lumbar spine and that he was stacking cases of juice in a small space and noticed a pop and sudden pain in his back. He agreed there was nothing in that history regarding a crowbar. Dr. Kennedy was also read a history from Dr. Anderson's records, noting that Dr. Anderson was a pain management physician who also treated Petitioner. The history was that while bending over to pick up a case, he noticed an acute onset of low back pain. Dr. Kennedy again agreed there was nothing in that history regarding a crowbar. The Arbitrator notes that Dr. Anderson's records, including the record referenced above, were not proffered at the hearing and are thus not part of the record. PX3.

Continuing on cross-examination, when asked under what circumstances he would prescribe an MRI, Dr. Kennedy testified he would do so when a patient is having lumbar symptoms. He then acknowledged that a lumbar MRI performed on March 15, 2012, seven months before the date of accident, might correlate to a prior history of complaints. He testified that Petitioner told him he did not have significant problems with his low back prior to October 8, 2012. When asked if the MRI done seven months before the accident date would be reflective of Petitioner having significant problems, he testified that it depended on the particular reason the MRI was done. PX3.

Dr. Kennedy testified the key issue was that Petitioner was exerting himself and doing a strenuous activity at the time of his injury, whether he was using the crowbar or not. When advised that Petitioner had told Dr. Burger that he had a longstanding history of low back pain radiating down both legs that was worse over the past six months, Dr. Kennedy testified that that was not inconsistent with his causal connection opinion. PX3.

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

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

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accidental injury on October 8, 2012, that arose out of and in the course of his employment with Respondent. In so concluding, the Arbitrator finds significant the complete lack of history of the accident to Dr. Burger only eight days after it allegedly occurred, the inconsistencies as to the reported mechanism of accident and Petitioner's veracity with regard to same, and the glaring lack of medical records and testimony that, if favorable to Petitioner, would have bolstered his case.

Petitioner testified that he was injured when he used a crowbar to unjam a pallet, twisted the pallet, and then heard a pop in his back followed by pain so severe it caused him to drop to his knees. He testified that he eased his way out of the palletizer and that two co-workers helped him finish his work. The first medical record in evidence following this was Dr. Burger's office note of October 16, 2012. The Arbitrator notes that this record was not admitted by Petitioner, but rather by Respondent. The history recorded by Dr. Burger was very specific and bears

repeating: "He is a 58-year-old man with a long-standing history of low back pain radiating down both legs, worse over the past six months....He has undergone a course of physical therapy with equivocal relief. He says he has undergone an MRI done at Memorial Hospital of the lumbar spine, the results of which are unavailable to me." This history is completely devoid of any mention of an incident at work eight days prior, which was reportedly so severe that it brought Petitioner to his knees. In addition, Dr. Burger also noted that Petitioner appeared to be in no distress, and that his back examination was normal. The Arbitrator finds this record to be compelling and arguably dispositive on its own as to accident.

The record is silent as to what treatment, if any, Petitioner sought between Dr. Burger's visit on October 16 and his first visit with Dr. King on November 13, 2012. However, it is undisputed that he was referred to Dr. King by his attorney, and first saw him five weeks after the alleged accident.

Dr. King testified that Petitioner reported he was injured at work when he was bent over a pallet and noticed a pop and sudden pain in his back. Two days later, on November 15, Petitioner reported to the therapist in Dr. King's office that he was picking up cases of juice, inside a small space, twisting and turning and trying to get them on a pallet, when he heard a pop followed by pain in his back. The Arbitrator notes that not only are these histories inconsistent with each other, but they are also inconsistent with Petitioner's testimony that he was unjamming a pallet with a crowbar and, while twisting the pallet straight and putting the product back on the pallet, he twisted and his back popped. There was also no mention on either day that the pain was so severe that it dropped Petitioner to his knees, as he testified to. In addition, Petitioner advised the therapist that he reported the incident to his employer after "waiting it out" for about a week. Whereas, Petitioner testified that he reported it the very next day.

Dr. King testified that Petitioner reported he had had back pain "off and on for awhile", which got worse after his work accident, and he conceded that he could not say that Petitioner's problem did not predate the alleged accident. In addition, Dr. King did not review medical records from Dr. Morgan or Dr. Burger, either before or after October 8, 2012, nor did he have the results of the MRI taken prior to that date. He admitted that such review would be helpful in providing a more accurate opinion on causal connection. Finally, Dr. King admitted that the accident, as reported by Petitioner, would be something memorable. He had no explanation for why Petitioner did not report it to Dr. Burger eight days after it allegedly occurred, but rather only reported a longstanding history of low back pain that was worse in the past six months.

The Arbitrator finds Dr. King's opinions to be based on inaccurate and incomplete information, and therefore not persuasive or credible.

Dr. Kennedy testified that Petitioner reported he was moving a stack of pallets, was bent over using a crowbar, and felt a pop in his lower back followed by pain. While this history is consistent with Petitioner's testimony at hearing, it is the first time there is any mention of the use of a crowbar, and it is inconsistent with the histories given to Dr. King and Dr. Bernardi. Yet, Dr. Kennedy did not find that fact to be of significance. He testified that by Petitioner's description, "he was straining pretty hard with the crowbar", leading him to conclude that the incident caused Petitioner's current condition. In addition, Dr. Kennedy testified that Petitioner

told him he did not have significant low back problems prior to October 8, 2012. Yet he did not review medical records from Dr. King, Dr. Morgan, or Dr. Burger, nor did he review Petitioner's MRI taken seven months prior to his alleged work accident. When asked whether the results of the previous MRI would change his opinion on causation, Dr. Kennedy testified it would not, as his opinion wasn't based on an anatomical change, but rather a clinical change. Yet, he conceded that the ordering of the MRI "might" correlate to a prior history of complaints. Without the benefit of reviewing the prior MRI, or Dr. Burger's report of October 16, eight days after Petitioner's alleged accident, it is perplexing how Dr. Kennedy could opine that the alleged accident caused a clinical change, thereby making all of his current complaints related thereto.

The Arbitrator finds Dr. Kennedy's opinions to be based on inaccurate and incomplete information, and therefore not persuasive or credible.

Dr. Bernardi testified that Petitioner reported he was injured when he was bent at the waist to pick up product and felt a pop followed by pain that took him to his knees. There was no mention of using a crowbar or a jammed pallet, in contradiction to Petitioner's testimony. He further reported that he waited a week before reporting the incident to his employer, which is also in contradiction to his testimony that he reported it the next morning. He asserted to Dr. Bernardi that, though he had prior bouts of back pain, they did not last more than one day. Dr. Bernardi found this to be incredulous, as clearly his symptoms were severe enough to warrant a lumbar MRI, lumbar x-rays, and a prescription pain medication. Further, he reviewed the previous MRI of March 15, 2012, and compared it to the MRI of January 29, 2013, and found the results to be identical. In addition, Dr. Bernardi testified that Dr. Burger's report of October 16, 2012, wherein there is no mention of a work accident, argued against a causal connection between Petitioner's current symptoms and any alleged incident occurring only eight days prior.

The Arbitrator finds Dr. Bernardi's opinions and explanations thereof to be compelling and persuasive. The Arbitrator further finds Petitioner to be lacking in veracity, based upon his testimony, his frequently changing history of the accident, and his lack of reporting any accident whatsoever to Dr. Burger only eight days thereafter.

The Arbitrator notes that Petitioner testified that two co-workers were aware of his accident and helped him out after it occurred; yet, knowing Respondent denied an accident occurred, he did not call either co-worker to testify on his behalf. Further, he testified that he reported the accident the next morning and that he eventually talked with three different people in management positions regarding the accident. Yet he presented no injury reports or testimony in support of his assertion and the record consistently notes he did not report the accident for a week. The Arbitrator further notes that Petitioner did not proffer medical records from any treating physician other than Dr. Kennedy. It was clear from the record that Respondent denied accident and causation, yet Petitioner presented no medical records which would support his position that his prior low back problems and treatment were minor and inconsequential.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment. 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 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

Janet Servi,
Petitioner,

18IWCC0395

vs.

NO: 15 WC 20113

State of Illinois CMS,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 11, 2017, is hereby affirmed and adopted.

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

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

DATED: JUN 19 2018
o6/7/18
DLS/rm
046

David L. Gore

Stephen J. Mathis

DISSENT

I respectfully dissent from the Decision of the majority. I would have found that Petitioner did not sustain her burden of proving that her bilateral carpal tunnel syndrome was related to her work activities, reversed the Decision of the Arbitrator, and denied compensation.

Petitioner is a data processing supervisor. She alleged work-related bilateral carpal tunnel syndrome that manifested itself on August 4, 2014. Petitioner testified that in her job she was on a keyboard for 90% of the time. Her recently retired supervisor estimated she would be on a keyboard about 80% of the time. The Arbitrator found that her job activities were of such a nature to cause her carpal tunnel syndrome. He relied on the causation opinion of Petitioner's treating surgeon, Dr. Greatting, which he found more persuasive than that of Respondent's Section 12 medical examiner, Dr. Stewart.

On her first visit to Dr. Greatting, he informed her it would be difficult to state that her work activities directly caused her carpal tunnel syndrome. However, based on her history of frequent keyboarding and repetitive use of a mouse could certainly be an activity which would aggravate or accelerate her symptoms. He eventually performed bilateral carpal tunnel release surgeries.

Dr. Stewart examined Petitioner on October 26, 2015. In reviewing her past medical history, he noted that Petitioner was referred to a rheumatologist in 2010 for upper extremity neuropathies. Petitioner informed him that her keyboard was on a drawer which pulled out from the desk and that the keyboard could be adjusted. He had her demonstrate how she performed her activities on a computer. He noted that she had a "reasonable and comfortable wrist position which would not place any increased pressure on the median nerve due to excessive flexion or extension."

Dr. Stewart stressed that an increased risk of compressive neuropathies required both repetitive and prolonged forceful grasping/gripping and/or vibration. Force and vibration were completely absent from Petitioner's job activities. Dr. Stewart opined that Petitioner's work activities did not contribute to her developing bilateral carpal tunnel syndrome. He cited a Mayo Clinic study which concluded that data entry activities did not increase the risk of compressive neuropathies.

In my opinion, Dr. Stewart had a better understanding than Dr. Greatting of Petitioner's specific job activities, by having her demonstrate how she performed her work activities. In contrast, Dr. Greatting based his rather equivocal causation opinion only on Petitioner's history of frequent typing and repetitive use of a mouse. I agree with Dr. Stewart and believe that the predominant current medical opinion posits that activities must involve more than simple repetitive finger manipulation to cause compressive neuropathies. Rather, activities must involve forceful gipping/grasping, vibration, or the extreme and extended flexion/extension of joints. Petitioner did not prove that her work activities involve such forces.

In addition, Dr. Stewart's assessment and my interpretation are in accord with the Commission decision in *Bowman v. R&B Receivables,* 14 I.W.C.C. 18700 (2016). There, the Commission denied compensation for a claimant who claimed up to 6.5 hours of straight typing a day but presented no evidence of sustained forceful activities/gripping, heavy lifting, awkward positioning, or vibration.

Based on the record before us, I would have found that Petitioner did not sustain her burden of proving a causal connection between her work activities and her bilateral carpal tunnel syndrome, reversed the Decision of the Arbitrator, and denied compensation. For the reasons outlined above, I respectfully dissent.

RWW/dw
46

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0395

SERVI, JANET
Employee/Petitioner

Case# **15WC020113**

STATE OF ILLINOIS CMS
Employer/Respondent

On 5/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5757 MARTIN J HAXEL PC
310 N E ADAMS ST
SPRINGFIELD, IL 62701

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

4993 ASSISTANT ATTORNEY GENERAL
CHELSEA GRUBB
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

MAY 11 2017

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

18IWCC0395

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

Janet Servi
Employee/Petitioner

v.

State of Illinois, CMS
Employer/Respondent

Case # 15 WC 20113

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **3-28-17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8-4-14**, 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 **$70,529.68**; the average weekly wage was **$1356.34**.

On the date of accident, Petitioner was **57** 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 **$11,715.71** under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services of **$18,057.00**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of **$11,715.71** 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.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $904.23/week for $4^{5/7}$ weeks, commencing 10/17/14 through 11/3/14 and 6/9/15 through 6/23/15, as provided in Section 8(b) of the Act.

Permanent Partial Disability: Schedule injury (For injuries before 9/1/11)

Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 25.625 weeks, because the injuries sustained caused the 12.5% loss of the Petitioner's dominant, right hand, as provided in Section 8(e) of the Act.

Permanent Partial Disability: Schedule injury (For injuries before 9/1/11)

Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 20.5 weeks, because the injuries sustained caused the 10% loss of the Petitioner's left hand, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

5/10/17
Date

MAY 11 2017

FINDINGS OF FACT

Jay Kristin testified on behalf of the Petitioner. He used to be the Petitioner's immediate supervisor but retired in 2016. He also used to perform Petitioner's job many years ago and is familiar with Petitioner's job duties.

Kristin described the various computer operations and programs Petitioner operated and monitored every day at work. Whenever mistakes were encountered corrections had to be made. He estimated that at least 80% of Petitioner's job duties involved work on the computer. Kristin examined PX 9 and agreed it was a list of the computer functions that the Petitioner performed on the computer each day at work. He also said the department was short-staffed which resulted in more work for everyone else.

On cross-examination Kristin testified in even greater detail about the specific jobs Petitioner had to perform and explained that some of those jobs might contain 100 different steps in order to complete. Everything was done on the computer except for short periods of time when Petitioner was on the phone.

Petitioner testified that she has been continuously employed by the State of Illinois since the year 2000. She has worked for both the Department of Revenue and Central Management Services. Her job title is Data Processing Supervisor III. She was present for the testimony of her former supervisor, Kristin, and agrees with his testimony except that she said she would spend 90% of each work day on the computer. Petitioner identified PX 9 which is a list of specific computer functions she prepared listing what she does during each work day. This exhibit states that petitioner monitors 9 agencies and four different systems with the use of two computer monitors. PX 9 also lists approximately 15 other tasks performed on the computer each day.

Petitioner further testified that in the summer of 2014 she noticed that the thumbs, index fingers and long fingers of both hands were feeling numb with a tingling sensation. She went to see Dr. Fortin's physician assistant (Chris Carver) who noted the symptoms and referred her to Dr. Fortin for an EMG test (PX1). Dr. Fortin performed this test on August 2, 2014 and diagnosed petitioner with a bilateral carpal tunnel syndrome, severe, worse than in 2012. An EMG had been performed by Dr. Fortin in 2012 for petitioner's cervical problems. The 2012 EMG was positive for cervical radiculopathy and mild carpal tunnel syndrome on the left (PX 2). Petitioner testified that, despite the result of the 2012 test, she never experienced any numbness or tingling in her fingers prior to the summer of 2014.

Petitioner was referred to Dr. Greatting. Petitioner's medical history form dated September 16, 2014 indicated that her symptoms began in July 2014 and that typing, driving and gripping made her symptoms worse. Dr. Greattting confirm the diagnosis of bilateral carpal tunnel syndrome and, with regard to causal connection, stated in the office visit note signed on September 24,

2014 "I do feel, based upon her history, that her work activities, including frequent keyboarding and repetitive use of a mouse can certainly be an activity which would aggravate or accelerate her symptoms." Petitioner was scheduled for surgery for both hands (PX 3).

Before Petitioner had her first surgery she fell and injured her left wrist. This was not a work injury. Petitioner went to the Springfield Clinic Prompt Care and followed up with Dr. Western for the left wrist injury (PX 4; PX 5). She was diagnosed with a left wrist distal radius fracture, comminuted. She was referred back to Dr. Greattting.

Although the plan had been to decompress Petitioner's right wrist first, that plan changed as a result of the left wrist fracture. Dr. Greattting repaired the left wrist fracture during the same surgery that he decompressed Petitioner's carpal tunnel syndrome on October 17, 2014. Petitioner underwent a 2nd surgery the following month on the same wrist but this was due to the wrist fracture and not the carpal tunnel syndrome.

Petitioner fell and hurt her left wrist again on January 12, 2015 and saw Dr. Rishi who took x-rays and confirmed that there was no damage to the left wrist (PX 6).

Petitioner eventually had decompression surgery for her right carpal tunnel syndrome on June 9, 2015. Petitioner was released from care after an office visit on June 26, 2015 but Petitioner returned to see Dr. Greattting in August, 2015 (according to PX8, the medical bills) complaining of bilateral wrist and hand pain along with left shoulder pain. Petitioner had physical therapy in October for the wrists, hands and left shoulder (PX 7). Petitioner's final office visit with Dr. Greatting was on October 14, 2015. On that date it is noted that Petitioner still complained of right hand pain (PX 3).

Petitioner further testified that she followed up with a doctor in St. Louis who performed another surgery on her left wrist as a result of the fracture and that doctor eventually performed another carpal tunnel release on the left hand. However, Petitioner is not seeking any compensation for any of the treatment she received in St. Louis.

At arbitration Petitioner testified that the decompression surgeries helped but she still feels numbness on the tips of both thumbs, both index fingers and both long fingers. She makes a a lot of mistakes while keyboarding at work because she cannot feel that her fingers are on the correct keys. She has difficulty picking up things off the floor because of the lack of sensation in her fingertips and has a lot of trouble turning doorknobs and opening jars. She had no plans to obtain any additional treatment; she's not aware of anything that would help.

On cross-examination Petitioner further described her job duties. She admitted to having trigger thumb in 2010 but after receiving an injection those symptoms disappeared.

No one testified on behalf of of the Respondent. RX1 is the IME report of Dr. Stewart who examined Petitioner on October 26, 2015. Petitioner's subjective complaints on that date are

consistent with her trial testimony. Dr. Stewart opined that Petitioner's job duties were repetitive but not forceful so there is no connection between her work activities and her carpal tunnel syndrome (pages 7 and 8, RX1).

RX2 is Petitioner's job description which corroborates her testimony as well as that of her supervisor.

CONCLUSIONS OF LAW

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

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

The Arbitrator concludes that Petitioner did sustain an injury arising out of and in the course of her employment and that her current condition of ill-being is causally connected to the work injury. The evidence concerning Petitioner's keyboarding and computer use is credible, consistent and impressive. She has been spending 80%-90% of her time on the computer for more than 10 years. Petitioner's testimony is corroborated by the testimony of her former supervisor, the written job description as well as her list of computer-related tasks that she performs each day. Respondent offered no evidence to refute this.

Petitioner's treating surgeon, Dr. Greatting, opined that Petitioner's work activities could certainly aggravate or accelerate the development of carpal tunnel syndrome. Dr. Fortin, who performed the EMG test, opined that Petitioner's problems may be a worker's compensation case (PX 2).

Respondent depends upon the opinion of its Section 12 examiner, Dr. Stewart, who agreed that Petitioner's job activities were repetitive but was of the opinion that the keyboarding activities lacked the necessary force to constitute a cause in the development of Petitioner's bilateral carpal tunnel syndrome.

Petitioner's testimony is corroborated by the medical records. There is no doubt but that she performed repetitive activity for well over a decade. The evidence also conclusively proves that keyboarding worsed and her symptoms. Based upon the record taken as a whole the Arbitrator finds the opinion of Dr. Greatting much more persuasive than that of Dr. Stewart and concludes that Petitioner has proven the existence of a work-related injury as well as a causal connection between her current condition of ill-being.

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?

Given the Arbitrator's conclusions regarding accident and causal connection, Respondent is responsible for the medical treatment she received for her carpal tunnel syndrome. Petitioner testified that all of her medical providers were affiliated with Springfield Clinic and these included Chris Carver, physician's assistant; Dr. Fortin; Dr. Greatting; physical therapists along with one office visit with Dr. McClintock and an EKG test that was necessary for a pre-surgery examination.

However, Respondent is not liable for any medical treatment for Petitioner's left wrist fracture. After examining the medical bills (PX 8) the Respondent is liable for the following dates of service (and the amounts, where indicated) which are found to be causally connected to Petitioners' carpal tunnel syndrome:

July 23, 2014: Christine Carver, P. A.

August 4, 2014: Dr. Claude Fortin
September 18, 2014: Dr. Mark Greatting
October 16, 2014: Dr. Greatting
October 17, 2014: Dr. Greatting (carpal tunnel surgery charge of $3100).
October 17, 2014: Ambulatory Surgery Center ($2763).
October 17, 2014: Dr. Christopher Ryan, anesthesia ($800).
October 17, 2014: Dr. Greatting (surgery charge of $775).
November 5, 2014: Dr. McClintock
November 5, 2014: electrocardiogram
May 28, 2015: Dr. Greatting
June 9, 2015 Dr. Greatting
June 9, 2000 15 Ambulatory Surgery Ctr.
June 9, 2015: Dr. Thomas Neil Rooke, anesthesia
June 24, 2015 Dr. Greatting
October 1, 2015 Dr. Greatting
October 2, 2015 Rehabilitation Services (physical therapy)
October 9, 2015 Rehabilitation Services
October 10, 2013 Rehabilitation Services
October 14, 2015 Dr. Greatting
October 15, 2015 Rehabilitation Services

Respondent shall pay reasonable and necessary medical services for the charges and the dates of service set forth above as provided in Sections 8 (a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that a 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. Moreover, Respondent shall reimburse Petitioner's out-of-pocket medical payments in the total sum of $270.

Issue K: What temporary benefits are in dispute?

Given the Arbitrator's conclusions regarding accident and causal connection, Petitioner is entitled to temporary total disability benefits. The parties stipulated at the length of Petitioner's off-work time was 4 and 5/7 weeks. The parties stipulated that petitioner's average weekly wage was $1356.34.

Respondent shall pay Petitioner temporary total disability benefits of $904.23 per week for 4 5/7 weeks as provided in section 8 (b) of the Act.

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

Pursuant to section 8.1b of the Act, 5 factors must be considered in assessing permanent partial disability.

1). The reported level of impairment under AMA guidelines. No evidence was presented by either party with regard to this factor.

2). The occupation of the injured employee. Petitioner returned to work at her current job and performs the same work activities as before the date of accident.

3). The age of the employee at the time of the injury. At the time of her accident Petitioner was 57 years old. No other evidence presented with regard to this factor.

4). The employee's future earning capacity. No evidence was presented with regard to this factor.

5). Evidence of disability corroborated by the treating medical records. Petitioner underwent bilateral carpal tunnel surgeries performed by Dr. Greatting. Approximately 3 months after the 2nd surgery had been completed petitioner returned to Dr. Greatting complaining about continued problems in her hands and wrists, among other complaints. As a result Petitioner underwent a course of physical therapy before being released from further treatment by Dr. Greatting.

Petitioner testified at arbitration that she still has a loss of sensation in both thumbs, both index fingers in both long fingers. This testimony is corroborated by the complaints documented by the Section 12 examiner, Dr. Stewart. Petitioner described how these remaining symptoms affect her ability to work as well as perform some tasks of normal living. Despite the fact that Petitioner sustained a fracture of her left wrist, the remaining symptoms in that hand attributable to carpal tunnel syndrome and are the same as those in the right hand.

Upon consideration of all of the evidence, the Arbitrator concludes that Petitioner has sustained permanent partial disability of 12.5% of the right, dominant hand and has also sustained permanent partial disability of 10% of the left hand.

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

SEAN VINCENT JEFFRIES,
Petitioner,

vs.

NO: 08 WC 56095

CITY OF CHICAGO,
Respondent,

18IWCC0396

DECISION AND OPINION ON REVIEW

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

Petitioner filed three connected cases, 08WC056095 (alleged date of accident of August 27, 2008), 13WC005576 (alleged date of accident of January 8, 2013), and 14WC029797 (alleged date of accident of August 25, 2014). The cases were consolidated. All three cases involved Petitioner's left foot. The Arbitrator awarded Petitioner temporary total disability ("TTD") previously paid, as well as 20% loss of use of the left foot in case 08WC056095, and denied accident in cases 13WC00576 and 14WC029797. The Commission affirms the Arbitrator, but clarifies the decision as stated below.

In case 08WC056095, the Arbitrator found that Petitioner proved accident and causation, and awarded Petitioner 20% loss of use of the left foot, resulting in an award of $22,201.65, as well as that TTD was properly paid and Respondent was entitled to a credit for payments made. The Commission affirms the permanency award of the Arbitrator. As to TTD, Respondent receives a credit for payments made in the amount of $51,801.86. The Commission clarifies that the dates for which Respondent has issued payment are August 29, 2008 through November 22, 2009 for a period representing 64 3/7 weeks. The Respondent is additionally entitled to a credit of $2,658.88 for an advance of permanent partial disability.

The Arbitrator denied accident in 13WC5576. The Commission affirms that decision. However, the Respondent paid TTD in the amount of $72,603.68, representing the date range of January 9, 2013 through July 25, 2014 for a period of 80 2/7 weeks. Respondent additionally

18IWCC0396

paid $3,481.88 in maintenance. The Arbitrator ruled that the Respondent is entitled to a credit in the amount of $76,603.68. The Commission affirms that decision. The Arbitrator denied Petitioner's claim for benefits in case 14WC029797.

The Commission hereby applies the credit awarded in 13WC5576 against the remaining value of any permanency award in the instant case, leaving a final award to Petitioner in the amount of $0. Respondent is credited $57,060.91 in overpaid disability benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 2, 2016, is hereby clarified and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $804.16 per week for a period of 64 3/7 weeks, between August 29, 2008 and November 22, 2009, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent receives a credit for payments made in the amount of $51,801.86.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 33.4 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 20% loss of use of the left foot. Respondent is issued a credit of $79,262.56 to be offset against the permanency award.

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 20 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 042518
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JEFFERIES, SEAN
Employee/Petitioner

Case# **08WC056095**

13WC005576
14WC029797

CITY OF CHICAGO
Employer/Respondent

18IWCC0396

On 8/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1747 SEIDMAN MARGULIS & FAIRMAN
STEVEN J SEIDMAN
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

0010 CITY OF CHICAGO LAW DEPT
ELIZABETH MANNION
30 N LASALLE ST 8TH FL
CHICAGO, IL 60602

☒ None of the above

ARBITRATION DECISION

City of Chicago
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 **Kurt Carlson** Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **April 7, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

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

18IWCC0396

On **8/27/2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the 8/27/08 injury, Petitioner earned **$62,724.48**; the average weekly wage was **$1,206.24.**

On the date of the 5/29/08 accident, Petitioner was **46** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$51,801.86** for TTD, **$00.00** for TPD. **$00.00** for maintenance, and **$2,658.88** for other benefits, for a total credit of **$54,460.74.**

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

ORDER

WITH RESPECT TO PETITIONER'S CLAIMS OF INJURY TO HIS LEFT FOOT, THE PETITIONER IS ENTITLED TO HAVE AND RECEIVE FROM RESPONDENT $664.72 FOR 33.4 WEEKS, REPRESENTING A 20% LOSS OF USE OF THE LEFT FOOT AS PROVIDED IN SECTION 8 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 — Date: 8-2-16

AUG 2 - 2016

FINDINGS OF FACT:

08 WC 56095

The parties stipulate that the City of Chicago (hereinafter referred to as the "respondent") was operating under the Illinois Workers' Compensation Act on August 27, 2008, and January 8, 2013. On these dates, Sean Jeffries, (hereinafter "petitioner") was working as motor truck driver for the City of Chicago's Department of Water Management.

Parties proceeded to hearing on April 7, 2016, with disputed issues as to accident, causation, TTD, and nature and extent of the injuries.

Petitioner testified on August 27, 2008, he was exiting his truck and slipped on some debris on the step of the truck landing on his left ankle and injuring it. (Tr. 11-12). Petitioner completed a Report of Occupational Injury that date, which he signed, attesting to a similar incident of "left foot contusion. Debris on truck steps. Exiting truck." (Rx 7). On cross-examination, Petitioner clarified that he did not fall to the ground in this incident. (Tr. 34-35). Outside of the left foot, Petitioner claimed no other body parts as injured.

Petitioner went to Mercy Hospital that date, where he was diagnosed with a left foot contusion. (Rx 1). Petitioner followed up care with Mercy Work on August 28, 2008. X-rays showed no acute injury and he was diagnosed with left foot sprain and contusion. (Rx 2, p.2). On September 3, 2008, the Dr. Sheth of Mercy Works noted Petitioner was using a cane, although the records are unclear as to whether it was prescribed. (Rx 2, p. 2). The medical records also show Petitioner sustained a first toe nail bed avulsion. (Rx 2, p.3). Dr. Pern's medical records from September 8, 2008 detail that Petitioner stated "He was wearing a flip-flop type of shoe" when he slipped down the stair of the truck, "which caused him to avulse or tear off his great toenail on the left foot." Dr. Perns detailed in his office visit note, "He states he was given a note to wear no steel toe shoes because of heel pain on the left side but I questioned him wearing a flip-flop type of shoe versus a gym shoe and he stated that the flip-flop felt better than the gym shoe." (Rx 3). When questioned on cross-examination if Petitioner sustained a toe-nail wound as a result of this incident, Petitioner testified he could not recall. Tr. 36. Petitioner testified that he was not wearing flip flops on the date of accident and that the medical records were incorrect. Petitioner further could not recall telling Dr. Perns about his prior heel problems requiring him to wear flip flops at work. Tr. 36-37.

Petitioner's foreman at the City of Chicago, Mr. Norman Clark testified at the arbitration hearing. Mr. Clark has worked as a foreman for the City of Chicago for 13 years in the Department of Water. (Tr. 118). As a foreman, his job entails dispatching all drivers to their locations, assigning them trucks, and maintaining all the trucks in the fleet. Mr. Clark also supervises employees in their job descriptions, handing permission for vacations, and granting vacation days or sick days. He supervised Mr. Jefferies beginning approximately 6 years ago (2010). Tr. 119.

Mr. Clark testified that as part of the department's uniform/dress code, motor truck drivers must wear steel-toed shoes or boots. Further, if an employee claimed medical reasons for needing to wear flip-pages or sandals, it would not be permitted. (Tr. 123-124).

Petitioner admitted on cross-examination that he complained to his doctor about right ankle pain in late 2008, but denied any history of right ankle pain prior to that point. Tr. 38. X-rays were

taken at that time. (Rx 1). Petitioner testified he only hurt his left ankle in the August 27, 2008 incident. (Tr. 35).

Petitioner continued to treat with Mercy Works and Dr. Perns for his left ankle. On April 16, 2009, he underwent left ankle arthroscopy, excision of anterior tibial osteophyte, and synovectomy debridement with Dr. Westin. (Rx 4). Petitioner followed up treatment with physical therapy. He was released back to work full duty on November 23, 2009. He was paid TTD benefits while he was off work until his release back to work. (Rx 2, p. 9). Petitioner returned to Mercy Works on February 16, 2010 complaining of pain in his knees and both ankles. Petitioner was kept at full duty. (Rx 2, p. 10).

Petitioner continued to work full duty and resumed his regular work hours. (Tr. 39, 40). He testified he had another work incident involving his hand which he resolved via settlement. (Tr. 40).

13 WC 5576

Petitioner filed a claim for injuries for a claimed date of accident of January 8, 2013. On direct examination Petitioner testified that he stepped on something that seemed like a big rock, and his ankle twisted. He then stepped up on the truck, and his left foot got caught on the bottom of the truck carriage or steps, and it twisted again. Tr. 18. Petitioner testified he sought care at the end of his shift on January 9, 2013, as Petitioner worked until 7 a.m. the next day. (Tr. 19). On cross-examination, when asked if he saw the rock he stepped on, he stated "it was dark." (Tr. 41). The Report of Occupational Injury for that date reported "left foot and ankle entering truck caught in undercarriage of truck." (Rx 8). Petitioner testified he only injured his left ankle in this incident. (Tr. 42-43). There were no witnesses to this incident.

Petitioner's supervisor and foreman at the time of this incident, Normal Clark testified at the arbitration hearing that in January 2013, at around 3:00 a.m., Mr. Clark got a call from his supervisor saying that he caught Mr. Jeffries sleeping, and that he was to write him up and start discipline actions. Then, Mr. Clark was notified once he got to work that Petitioner "got hurt or injured on the job prior to." (Tr. 127-128). Mr. Clark testified he could not take any disciplinary action, because the day he got caught sleeping on the job, he had later reported a work injury. (Tr. 121).

It is also noted that Petitioner had requested FMLA on January 2, 2013, "to care for his mother." (Rx 12). His application was pending and had not yet been approved at the time of this January 8, 2013 work incident. (Tr. 105) Ms. Marisol Santiago, Director of Administration at the Water Department, testified at the arbitration hearing. Ms. Santiago oversees the personnel, human resources and payroll division for the department. (Tr. 95). The human resources division is responsible for processing all employees' leaves of absences, resignations, retirements, new hire processing, payroll, vacation payouts, and employee relation issues. (Tr. 95). Ms. Santiago testified that an employee would not be paid by the City of Chicago under FMLA for that time off. (Tr. 105).

Petitioner reported to Mercy Works on January 8, 2013, and reported a twisting injury to his left ankle from his foot slipping while he was climbing up into the truck. (Rx 13, p.2). There was no mention in the records of the rock-like object Petitioner testified to tripping over at the hearing. X-rays were taken at that time showing no fracture, and Petitioner was diagnosed with a "sprain, left anke and left foot." (Id.). There was no ecchymosis upon examination. (Id.). Petitioner

returned to Mercy Works on January 15, 2013, at which point a MRI was recommended. Treatment recommendations included an elastic ankle support, cane, ibuprofen and Norco. (Id.). Petitioner underwent a MRI on January 19, 2013, which Mercy Works noted as a ligamental tear of his left ankle and impingement syndrome.

Petitioner began treating with his choice of physical Dr. Simon Lee at Midwest Orthopedic at Rush on January 31, 2013. (Px 16)(Tr. 43). Petitioner reported to Dr. Lee a similar accounting of his foot being lodged in the undercarriage when stepping into his truck. However, he also reported his "ankle gave way" seven hours later into his shift on January 8, 2013, causing him to fall. (Px 16, DOS 1/31/13). Petitioner did not report any fall on his incident report or at trial. Dr. Lee reviewed the January 2013 MRI and compared it to the 2008 MRI of Petitioner's left ankle, and found Petitioner had a "left osteochondral lesion of the posteromedial talar dome that appeared "to have some collapse as compared to in 2008 with increased edema formation as well as a small cyst underneath the OCD, this is not present in 2008." (Px 16, DOS 2/25/13).

On February 25, 2013, Dr. Lee recommended continued use of the Cam boot and for Petitioner to begin physical therapy. On March 25, 2013, Dr. Lee recommended continued physical therapy and a start to weaning out of the Cam Walker. (Px 16). On May 13, 2013, due to continued pain, Dr. Lee administered a corticosteroid injection and discussed possible surgery in the future. An MRI taken between visits showed the osteochondral injury involving the medial talar dome appeared stable to minimally decreased with surrounding bony marrow edema since the prior study. (Px 16, 5/13/13). On June 20, 2013, Dr. Lee noted the injury as a left ankle injury with sprain and contusion resulting in a re-aggravation of his previous left medial talar OCD." (Px 16).

Petitioner attended an IME with Dr. Michael Pinzur of Loyloa University Medical Center on August 9, 2014, who found the injury to be an exacerbation of if his pre-existing condition, and agreed with Dr. Lee's recommendations for repeat surgery, even finding Dr. Lee to be a well-trained surgical arthroscopist. (Rx 15). Petitioner underwent left ankle arthroscopy, extensive debridement, and then open posteromedial arthrotomy with repair of the osteochondral defect of the talas with Dr. Lee on September 27, 2013. (Px 16). The post-operative diagnosis was left posteromedial OCD ankle and impingement bursitis. (Px 16).

Petitioner followed up treatment with physical therapy and Dr. Lee at Midwest Orthopaedics at Rush. On November 4, 2013, 10 months following this incident, Petitioner first mentioned his right ankle having intermittent soreness. (Px 16). On January 27, 2014, Dr. Lee noted Petitioner reported complaints to his right ankle and right shoulder, which Dr. Lee found "abnormal for the normal postsurgical." Further, Dr. Lee advised Petitioner there is no specific anatomical nature to his symptoms." Dr. Lee ordered additional MRI to evaluate the left ankle for any abnormal post-surgical changes. As for the right ankle, testing was ordered to see if there was any soft tissue pathology to that would be causing his abnormal issues with his non-operated ankle. (Px 16). An MRI of the right ankle, which was not injured in the incident, similarly showed an osteochondral lesion with a tiny amount of bone marrow edema. Petitioner also had a right foot chronic mild ATFL injury, findings associated with injury to the deep deltoid ligament, chronic mild ATFL injury, and mild plantar fasciits. (Px 16, DOS 2/26/14).

At trial, Petitioner denied any pre-existing or unrelated right ankle problems at hearing, additionally, Petitioner testified that only his left ankle was injured in the January 2013 incident. (Tr. 43-44). Dr. Lee ordered an FCE on June 2, 2014. Dr. Lee also recommended Petitioner re-consult with Dr. Pinzur to see if he believed there were any further treatment options or recommendations or if Dr. Pinzur agreed with the IME status. (Px 16, DOS 6/2/14). Dr. Lee also

found Petitioner's significant subjective complaints of pain were in discordance with the MRI. which showed improvement of original symptoms, complaints and edema. (Id.).

Petitioner went to second IME with Dr. Pinzur on June 27, 2014. (Rx 15). Dr. Pinzur noted Petitioner appeared at the evaluation with his cane. Dr. Pinzur found Petitioner had reached MMI, and opined Petitioner's injury contributed to his chronic condition, but was not fully responsible as he had a pre-existing disease. Dr. Pinzur found Petitioner had a favorable outcome from his surgery, and found and FCE to be very reasonable moving forward. (Id.).

Petitioner underwent and FCE on July 11, 2014. Petitioner exhibited an inconsistent effort in his performance, and the FCE documented that the overall results of the evaluation did not represent a true and accurate representation of Petitioner's overall physical capabilities and tolerances, suggesting a minimal level of function. The FCE report outlined "GIVEN THE FACT THAT THE CLIENT DEMONSTRATED 47.7% INCONSISTENT EFFORT, HE IS CAPABLE OF GREATER FUNCTIONAL ABILITIES THAN THAT DEMONSTRATED DURING THE FCE." Additionally, Petitioner demonstrated 77.8% inconsistent reliability of pain. The recommendations found Petitioner to be functionally employable. (Rx 6).

Dr. Lee released Petitioner back to work with permanent restrictions on August 1, 2014 with partial lifting of 30-40 lbs, and partial climbing. (Rx 17).

Petitioner testified he met with City of Chicago for reinstatement on or about Friday, August 22, 2014. (Tr. 45). Petitioner then could not recall the exact date he started working. (Tr. 46). Petitioner testified when he was reinstated, he knew prior to going back of exactly what date he would be brought back to work. (Tr. 47). Petitioner testified that when he was reinstated, he did not request to be off for any additional time for any unrelated reasons outside of his workers' compensation injury. (Tr. 46).

About approximately six hours into his shift on Monday, August 25, 2014, Petitioner reported a new incident, which was filed under 14 WC 29797 (Tr. 47).

Petitioner seeks compensation for permanency and claimed outstanding medical for injuries to his left foot under claims 08 WC 56095 & 13 WC 5576. Respondent denies accident and causation, and seeks a credit for TTD/maintenance benefits paid under these claims.

CONCLUSIONS OF LAW:

Regarding (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; Regarding (F) Is Petitioner's current condition of ill-being causally related to the injury?; and Regarding (L) What is the nature and extent of the injury?

To be compensable under the Workers' Compensation Act, the injury complained of must be one "arising out of and in the course of the employment." *Ill.Rev.Stat.1991, ch. 48, par. 138.2.* The claimant has the burden of establishing both requirements. (*Castaneda v. Industrial Comm'n* (1983), 97 Ill.2d 338, 341, 73 Ill.Dec. 535, 454 N.E.2d 632.) An injury " 'arises out of' one's employment if its origin is in some risk connected with or incident to the employment, so that there is a causal connection between the employment and the accidental injury." *Jewel Cos. v. Industrial Comm'n (1974),* 57 Ill.2d 38, 40, 310 N.E.2d 12. "An injury is received in the course of employment where it occurs within a period of employment, at a place where the worker may

reasonably be in the performance of his duties, and while he is fulfilling those duties or engaged in something incidental thereto". *Scheffler Greenhouses, Inc. v. Industrial Comm'n (1977)*, 66 Ill.2d 361, 367, 5 Ill.Dec. 854, 362 N.E.2d 325.

When determining the above issues the Arbitrator must carefully weigh all of the evidence presented. This includes the credibility and testimony of the petitioner. The weight of a witness's testimony depends upon that witness's personal credibility. Once the petitioner's credibility is questioned, the concept of truthfulness becomes critical.

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 than 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).

Additionally, 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*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

Overall, the Petitioner did not appear credible. Thus, the Arbitrator relies on the medical records and evidence, the testimony of the supervisor for a determination.

08 WC 56095

In regards to Petitioner's claim for injury for date of accident August 27, 2008, the Arbitrator finds Petitioner did sustain an accident that resulted in an aggravation of a pre-existing osteochondral defect condition in Petitioner's left foot, resulting in surgery on April 16, 2009. Petitioner underwent physical therapy and was released full duty on November 23, 2009. It is clear from the medical records that although no right ankle foot or knee injuries were sustained, Petitioner had complaints to these body parts, unrelated to the incident, which were symptomatic at this time. Thus the Petitioner's testimony that he had no pre-existing issues with his right ankle is found to be not credible.

This Arbitrator notes that Petitioner's testimony as to the incident itself and the resulting injuries conflict with the medical records, specifically as to Petitioner's claim that he wearing steel toed boots on the date of accident. The medical records provide that Petitioner reported wearing a flip flop type shoe, and even sustained a nail avulsion. Although Petitioner's failure to follow uniform protocol does not take his accident outside the scope of employment, his denial of these issues raises questions as to his credibility. Additionally, the medical records following that date of accident show Petitioner reporting he had long standing ankle problems, as he claimed a "medical note" excusing him from wearing the uniform required foot wear.

With respect to Petitioner's claims of injury to his left ankle under claim 08 WC 56095, the Petitioner is entitled to have and receive from Respondent $664.72 for 33.4 weeks, representing a 20% loss of use of the left foot as provided in Section 8 of the Act.

In regards to Petitioner's claim for injury for date of Accident January 8, 2013, this Arbitrator finds that Petitioner failed to prove the accident. The Petitioner's testimony throughout the trial was not credible and in contradiction with the medical records.

Petitioner claims an unwitnessed accident on January 8, 2013 where he tripped on a rock-like object he did not see, and then caught his left foot in the undercarriage of the truck. Petitioner's supervisor at the time, Mr. Norman Clark, testified credibly at the hearing. Mr. Clark testified that on the alleged date of incident, Petitioner was caught sleeping on the job and was in line to be disciplined. No disciplinary action was taken as Petitioner reported an injury following his shift. Additionally, Mr. Clark testified that a motor truck driver, such as Petitioner, should always be with a crew. Yet, this incident was unwitnessed.

Petitioner also had applied for FMLA leave in early January for unrelated reasons. At the time of his alleged incident, his application had not been approved. Ms. Marisol Santiago, Director of Administration of the Water Department testified that FMLA leave would have been unpaid. The records reflect this request was approved by the Water Department following the alleged incident date.

Petitioner was off of work for this incident from January 9, 2013 until August 21, 2014. At trial, Petitioner only reported an injury to his left ankle from this incident. Again, medical records reflect long-standing, unrelated right ankle pain and treatment for it.

Petitioner underwent an additional left Petitioner underwent left ankle arthroscopy, extensive debridement, and then open posteromedial arthrotomy with repair of the osteochondral defect of the talas with Dr. Lee on September 27, 2013. Both the treating records and the IMEs of Dr. Pinzur make clear Petitioner had a chronic condition in his left foot that needed to be addressed. He was returned to work with restrictions following the failure of his FCE for inconsistent effort and 77.8% inconsistent reliability of pain.

Petitioner was able to return to work within his restrictions to the position of a motor truck driver, and reinstated on August 22, 2014.

The Arbitrator finds that Petitioner failed to prove an accident that occurred on January 8, 2013 that caused or aggravated Petitioner's condition. Thus, Petitioner's claim for benefits under 13 WC 5576 is denied.

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? (K)What temporary benefits are in dispute? TTD , and (N) Is Respondent due any credit?

The Arbitrator finds that Petitioner received reasonable and necessary medical treatment under claim 08 WC 56095, and TTD was properly paid, for which the Respondent receives a credit for payments made.

However, under claim 13 WC 5576, as Petitioner failed to prove accident and causation under the Act, the Respondent is due a credit for all TTD and maintenance benefits paid under this claim.

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

SEAN VINCENT JEFFERIES,
Petitioner,
vs.

NO: 13 WC 5576

CITY OF CHICAGO,
Respondent,

18IWCC0397

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, prospective medical treatment, 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 2, 2016 is hereby affirmed and adopted.

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

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

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

JUN 20 2018

DATED:

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/rlc
o042518
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JEFFRIES, SEAN
Employee/Petitioner

Case# **13WC005576**

08WC056095
14WC029797

CITY OF CHICAGO
Employer/Respondent

18IWCC0397

On 8/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1747 SEIDMAN MARGULIS & FAIRMAN
STEVEN J SEIDMAN
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

0010 CITY OF CHICAGO LAW DEPT
ELIZABETH MANNION
30 N LASALLE ST 8TH FL
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

18IWCC0397

☐ 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

Sean Jeffries
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 13 WC 5576

Consolidated cases: 08WC56095; 14WC29797

An *Application for Adjustment 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, Illinois**, on **April 7, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
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

18IWCC0397

On **1/8/13**, 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 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 1/8/13 injury, Petitioner earned $**70,408.00**; the average weekly wage was $**1,354.00.**

On the date of the 1/8/13 accident, Petitioner was **51** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**72,603.68** for TTD, $**00.00** for TPD, $**3,481.88** for maintenance, and $00.00 for other benefits, for a total credit of **$76,603.68.**

Respondent is entitled to a credit of $**882.02** under Section 8(j) of the Act.

ORDER

PETITIONER'S CLAIM FOR BENEFITS IS DENIED AS PETITIONER FAILED TO PROVE ACCIDENT. RESPONDENT IS DUE A CREDIT FOR TTD AND MAINTENANCE BENEFITS 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

8-2-16
Date

AUG 2 - 2016

FINDINGS OF FACT:

18IWCC0397

08 WC 56095

The parties stipulate that the City of Chicago (hereinafter referred to as the "respondent") was operating under the Illinois Workers' Compensation Act on August 27, 2008, and January 8, 2013. On these dates, Sean Jeffries, (hereinafter "petitioner") was working as motor truck driver for the City of Chicago's Department of Water Management.

Parties proceeded to hearing on April 7, 2016, with disputed issues as to accident, causation, TTD, and nature and extent of the injuries.

Petitioner testified on August 27, 2008, he was exiting his truck and slipped on some debris on the step of the truck landing on his left ankle and injuring it. (Tr. 11-12). Petitioner completed a Report of Occupational Injury that date, which he signed, attesting to a similar incident of "left foot contusion. Debris on truck steps. Exiting truck." (Rx 7). On cross-examination, Petitioner clarified that he did not fall to the ground in this incident. (Tr. 34-35). Outside of the left foot, Petitioner claimed no other body parts as injured.

Petitioner went to Mercy Hospital that date, where he was diagnosed with a left foot contusion. (Rx 1). Petitioner followed up care with Mercy Work on August 28, 2008. X-rays showed no acute injury and he was diagnosed with left foot sprain and contusion. (Rx 2, p.2). On September 3, 2008, the Dr. Sheth of Mercy Works noted Petitioner was using a cane, although the records are unclear as to whether it was prescribed. (Rx 2, p. 2). The medical records also show Petitioner sustained a first toe nail bed avulsion. (Rx 2, p.3). Dr. Pern's medical records from September 8, 2008 detail that Petitioner stated "He was wearing a flip-flop type of shoe" when he slipped down the stair of the truck, "which caused him to avulse or tear off his great toenail on the left foot." Dr. Perns detailed in his office visit note, "He states he was given a note to wear no steel toe shoes because of heel pain on the left side but I questioned him wearing a flip-flop type of shoe versus a gym shoe and he stated that the flip-flop felt better than the gym shoe." (Rx 3). When questioned on cross-examination if Petitioner sustained a toe-nail wound as a result of this incident, Petitioner testified he could not recall. Tr. 36. Petitioner testified that he was not wearing flip flops on the date of accident and that the medical records were incorrect. Petitioner further could not recall telling Dr. Perns about his prior heel problems requiring him to wear flip flops at work. Tr. 36-37.

Petitioner's foreman at the City of Chicago, Mr. Norman Clark testified at the arbitration hearing. Mr. Clark has worked as a foreman for the City of Chicago for 13 years in the Department of Water. (Tr. 118). As a foreman, his job entails dispatching all drivers to their locations, assigning them trucks, and maintaining all the trucks in the fleet. Mr. Clark also supervises employees in their job descriptions, handing permission for vacations, and granting vacation days or sick days. He supervised Mr. Jefferies beginning approximately 6 years ago (2010). Tr. 119.

Mr. Clark testified that as part of the department's uniform/dress code, motor truck drivers must wear steel-toed shoes or boots. Further, if an employee claimed medical reasons for needing to wear flip-pages or sandals, it would not be permitted. (Tr. 123-124).

Petitioner admitted on cross-examination that he complained to his doctor about right ankle pain in late 2008, but denied any history of right ankle pain prior to that point. Tr. 38. X-rays were

taken at that time. (Rx 1). Petitioner testified he only hurt his left ankle in the August 27, 2008 incident. (Tr. 35).

Petitioner continued to treat with Mercy Works and Dr. Perns for his left ankle. On April 16, 2009, he underwent left ankle arthroscopy, excision of anterior tibial osteophyte, and synovectomy debridement with Dr. Westin. (Rx 4). Petitioner followed up treatment with physical therapy. He was released back to work full duty on November 23, 2009. He was paid TTD benefits while he was off work until his release back to work. (Rx 2, p. 9). Petitioner returned to Mercy Works on February 16, 2010 complaining of pain in his knees and both ankles. Petitioner was kept at full duty. (Rx 2, p. 10).

Petitioner continued to work full duty and resumed his regular work hours. (Tr. 39, 40). He testified he had another work incident involving his hand which he resolved via settlement. (Tr. 40).

13 WC 5576

Petitioner filed a claim for injuries for a claimed date of accident of January 8, 2013. On direct examination Petitioner testified that he stepped on something that seemed like a big rock, and his ankle twisted. He then stepped up on the truck, and his left foot got caught on the bottom of the truck carriage or steps, and it twisted again. Tr. 18. Petitioner testified he sought care at the end of his shift on January 9, 2013, as Petitioner worked until 7 a.m. the next day. (Tr. 19). On cross-examination, when asked if he saw the rock he stepped on, he stated "it was dark." (Tr. 41). The Report of Occupational Injury for that date reported "left foot and ankle entering truck caught in undercarriage of truck." (Rx 8). Petitioner testified he only injured his left ankle in this incident. (Tr. 42-43). There were no witnesses to this incident.

Petitioner's supervisor and foreman at the time of this incident, Normal Clark testified at the arbitration hearing that in January 2013, at around 3:00 a.m., Mr. Clark got a call from his supervisor saying that he caught Mr. Jeffries sleeping, and that he was to write him up and start discipline actions. Then, Mr. Clark was notified once he got to work that Petitioner "got hurt or injured on the job prior to." (Tr. 127-128). Mr. Clark testified he could not take any disciplinary action, because the day he got caught sleeping on the job, he had later reported a work injury. (Tr. 121).

It is also noted that Petitioner had requested FMLA on January 2, 2013, "to care for his mother." (Rx 12). His application was pending and had not yet been approved at the time of this January 8, 2013 work incident. (Tr. 105) Ms. Marisol Santiago, Director of Administration at the Water Department, testified at the arbitration hearing. Ms. Santiago oversees the personnel, human resources and payroll division for the department. (Tr. 95). The human resources division is responsible for processing all employees' leaves of absences, resignations, retirements, new hire processing, payroll, vacation payouts, and employee relation issues. (Tr. 95). Ms. Santiago testified that an employee would not be paid by the City of Chicago under FMLA for that time off. (Tr. 105).

Petitioner reported to Mercy Works on January 8, 2013, and reported a twisting injury to his left ankle from his foot slipping while he was climbing up into the truck. (Rx 13, p.2). There was no mention in the records of the rock-like object Petitioner testified to tripping over at the hearing. X-rays were taken at that time showing no fracture, and Petitioner was diagnosed with a "sprain, left anke and left foot." (Id.). There was no ecchymosis upon examination. (Id.). Petitioner

returned to Mercy Works on January 15, 2013, at which point a MRI was recommended. Treatment recommendations included an elastic ankle support, cane, ibuprofen and Norco. (Id.). Petitioner underwent a MRI on January 19, 2013, which Mercy Works noted as a ligamental tear of his left ankle and impingement syndrome.

Petitioner began treating with his choice of physical Dr. Simon Lee at Midwest Orthopedic at Rush on January 31, 2013. (Px 16)(Tr. 43). Petitioner reported to Dr. Lee a similar accounting of his foot being lodged in the undercarriage when stepping into his truck. However, he also reported his "ankle gave way" seven hours later into his shift on January 8, 2013, causing him to fall. (Px 16, DOS 1/31/13). Petitioner did not report any fall on his incident report or at trial. Dr. Lee reviewed the January 2013 MRI and compared it to the 2008 MRI of Petitioner's left ankle, and found Petitioner had a "left osteochondral lesion of the posteromedial talar dome that appeared "to have some collapse as compared to in 2008 with increased edema formation as well as a small cyst underneath the OCD, this is not present in 2008." (Px 16, DOS 2/25/13).

On February 25, 2013, Dr. Lee recommended continued use of the Cam boot and for Petitioner to begin physical therapy. On March 25, 2013, Dr. Lee recommended continued physical therapy and a start to weaning out of the Cam Walker. (Px 16). On May 13, 2013, due to continued pain, Dr. Lee administered a corticosteroid injection and discussed possible surgery in the future. An MRI taken between visits showed the osteochondral injury involving the medial talar dome appeared stable to minimally decreased with surrounding bony marrow edema since the prior study. (Px 16, 5/13/13). On June 20, 2013, Dr. Lee noted the injury as a left ankle injury with sprain and contusion resulting in a re-aggravation of his previous left medial talar OCD." (Px 16).

Petitioner attended an IME with Dr. Michael Pinzur of Loyloa University Medical Center on August 9, 2014, who found the injury to be an exacerbation of if his pre-existing condition, and agreed with Dr. Lee's recommendations for repeat surgery, even finding Dr. Lee to be a well-trained surgical arthroscopist. (Rx 15). Petitioner underwent left ankle arthroscopy, extensive debridement, and then open posteromedial arthrotomy with repair of the osteochondral defect of the talas with Dr. Lee on September 27, 2013. (Px 16). The post-operative diagnosis was left posteromedial OCD ankle and impingement bursitis. (Px 16).

Petitioner followed up treatment with physical therapy and Dr. Lee at Midwest Orthopaedics at Rush. On November 4, 2013, 10 months following this incident, Petitioner first mentioned his right ankle having intermittent soreness. (Px 16). On January 27, 2014, Dr. Lee noted Petitioner reported complaints to his right ankle and right shoulder, which Dr. Lee found "abnormal for the normal postsurgical." Further, Dr. Lee advised Petitioner there is no specific anatomical nature to his symptoms." Dr. Lee ordered additional MRI to evaluate the left ankle for any abnormal post-surgical changes. As for the right ankle, testing was ordered to see if there was any soft tissue pathology to that would be causing his abnormal issues with his non-operated ankle. (Px 16). An MRI of the right ankle, which was not injured in the incident, similarly showed an osteochondral lesion with a tiny amount of bone marrow edema. Petitioner also had a right foot chronic mild ATFL injury, findings associated with injury to the deep deltoid ligament, chronic mild ATFL injury, and mild plantar fasciits. (Px 16, DOS 2/26/14).

At trial, Petitioner denied any pre-existing or unrelated right ankle problems at hearing, additionally, Petitioner testified that only his left ankle was injured in the January 2013 incident. (Tr. 43-44). Dr. Lee ordered an FCE on June 2, 2014. Dr. Lee also recommended Petitioner re-consult with Dr. Pinzur to see if he believed there were any further treatment options or recommendations or if Dr. Pinzur agreed with the IME status. (Px 16, DOS 6/2/14). Dr. Lee also

found Petitioner's significant subjective complaints of pain were in discordance with the MRI, which showed improvement of original symptoms, complaints and edema. (Id.).

Petitioner went to second IME with Dr. Pinzur on June 27, 2014. (Rx 15). Dr. Pinzur noted Petitioner appeared at the evaluation with his cane. Dr. Pinzur found Petitioner had reached MMI, and opined Petitioner's injury contributed to his chronic condition, but was not fully responsible as he had a pre-existing disease. Dr. Pinzur found Petitioner had a favorable outcome from his surgery, and found and FCE to be very reasonable moving forward. (Id.).

Petitioner underwent and FCE on July 11, 2014. Petitioner exhibited an inconsistent effort in his performance, and the FCE documented that the overall results of the evaluation did not represent a true and accurate representation of Petitioner's overall physical capabilities and tolerances, suggesting a minimal level of function. The FCE report outlined "GIVEN THE FACT THAT THE CLIENT DEMONSTRATED 47.7% INCONSISTENT EFFORT, HE IS CAPABLE OF GREATER FUNCTIONAL ABILITIES THAN THAT DEMONSTRATED DURING THE FCE." Additionally, Petitioner demonstrated 77.8% inconsistent reliability of pain. The recommendations found Petitioner to be functionally employable. (Rx 6).

Dr. Lee released Petitioner back to work with permanent restrictions on August 1, 2014 with partial lifting of 30-40 lbs, and partial climbing. (Rx 17).

Petitioner testified he met with City of Chicago for reinstatement on or about Friday, August 22, 2014. (Tr. 45). Petitioner then could not recall the exact date he started working. (Tr. 46). Petitioner testified when he was reinstated, he knew prior to going back of exactly what date he would be brought back to work. (Tr. 47). Petitioner testified that when he was reinstated, he did not request to be off for any additional time for any unrelated reasons outside of his workers' compensation injury. (Tr. 46).

About approximately six hours into his shift on Monday, August 25, 2014, Petitioner reported a new incident, which was filed under 14 WC 29797 (Tr. 47).

Petitioner seeks compensation for permanency and claimed outstanding medical for injuries to his left foot under claims 08 WC 56095 & 13 WC 5576. Respondent denies accident and causation, and seeks a credit for TTD/maintenance benefits paid under these claims.

CONCLUSIONS OF LAW:

Regarding (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; Regarding (F) Is Petitioner's current condition of ill-being causally related to the injury?; and Regarding (L) What is the nature and extent of the injury?

To be compensable under the Workers' Compensation Act, the injury complained of must be one "arising out of and in the course of the employment." *Ill.Rev.Stat.1991, ch. 48, par. 138.2.* The claimant has the burden of establishing both requirements. (*Castaneda v. Industrial Comm'n* (1983), 97 Ill.2d 338, 341, 73 Ill.Dec. 535, 454 N.E.2d 632.) An injury " 'arises out of one's employment if its origin is in some risk connected with or incident to the employment, so that there is a causal connection between the employment and the accidental injury." *Jewel Cos. v. Industrial Comm'n (1974),* 57 Ill.2d 38, 40, 310 N.E.2d 12. "An injury is received in the course of employment where it occurs within a period of employment, at a place where the worker may

reasonably be in the performance of his duties, and while he is fulfilling those duties or engaged in something incidental thereto". *Scheffler Greenhouses, Inc. v. Industrial Comm'n (1977)*, 66 Ill.2d 361, 367, 5 Ill.Dec. 854, 362 N.E.2d 325.

When determining the above issues the Arbitrator must carefully weigh all of the evidence presented. This includes the credibility and testimony of the petitioner. The weight of a witness's testimony depends upon that witness's personal credibility. Once the petitioner's credibility is questioned, the concept of truthfulness becomes critical.

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 than 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).

Additionally, 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*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

Overall, the Petitioner did not appear credible. Thus, the Arbitrator relies on the medical records and evidence, the testimony of the supervisor for a determination.

08 WC 56095

In regards to Petitioner's claim for injury for date of accident August 27, 2008, the Arbitrator finds Petitioner did sustain an accident that resulted in an aggravation of a pre-existing osteochondral defect condition in Petitioner's left foot, resulting in surgery on April 16, 2009. Petitioner underwent physical therapy and was released full duty on November 23, 2009. It is clear from the medical records that although no right ankle foot or knee injuries were sustained, Petitioner had complaints to these body parts, unrelated to the incident, which were symptomatic at this time. Thus the Petitioner's testimony that he had no pre-existing issues with his right ankle is found to be not credible.

This Arbitrator notes that Petitioner's testimony as to the incident itself and the resulting injuries conflict with the medical records, specifically as to Petitioner's claim that he wearing steel toed boots on the date of accident. The medical records provide that Petitioner reported wearing a flip flop type shoe, and even sustained a nail avulsion. Although Petitioner's failure to follow uniform protocol does not take his accident outside the scope of employment, his denial of these issues raises questions as to his credibility. Additionally, the medical records following that date of accident show Petitioner reporting he had long standing ankle problems, as he claimed a "medical note" excusing him from wearing the uniform required foot wear.

With respect to Petitioner's claims of injury to his left ankle under claim 08 WC 56095, the Petitioner is entitled to have and receive from Respondent $664.72 for 33.4 weeks, representing a 20% loss of use of the left foot as provided in Section 8 of the Act.

In regards to Petitioner's claim for injury for date of Accident January 8, 2013, this Arbitrator finds that Petitioner failed to prove the accident. The Petitioner's testimony throughout the trial was not credible and in contradiction with the medical records.

Petitioner claims an unwitnessed accident on January 8, 2013 where he tripped on a rock-like object he did not see, and then caught his left foot in the undercarriage of the truck. Petitioner's supervisor at the time, Mr. Norman Clark, testified credibly at the hearing. Mr. Clark testified that on the alleged date of incident, Petitioner was caught sleeping on the job and was in line to be disciplined. No disciplinary action was taken as Petitioner reported an injury following his shift. Additionally, Mr. Clark testified that a motor truck driver, such as Petitioner, should always be with a crew. Yet, this incident was unwitnessed.

Petitioner also had applied for FMLA leave in early January for unrelated reasons. At the time of his alleged incident, his application had not been approved. Ms. Marisol Santiago, Director of Administration of the Water Department testified that FMLA leave would have been unpaid. The records reflect this request was approved by the Water Department following the alleged incident date.

Petitioner was off of work for this incident from January 9, 2013 until August 21, 2014. At trial, Petitioner only reported an injury to his left ankle from this incident. Again, medical records reflect long-standing, unrelated right ankle pain and treatment for it.

Petitioner underwent an additional left Petitioner underwent left ankle arthroscopy, extensive debridement, and then open posteromedial arthrotomy with repair of the osteochondral defect of the talas with Dr. Lee on September 27, 2013. Both the treating records and the IMEs of Dr. Pinzur make clear Petitioner had a chronic condition in his left foot that needed to be addressed. He was returned to work with restrictions following the failure of his FCE for inconsistent effort and 77.8% inconsistent reliability of pain.

Petitioner was able to return to work within his restrictions to the position of a motor truck driver, and reinstated on August 22, 2014.

The Arbitrator finds that Petitioner failed to prove an accident that occurred on January 8, 2013 that caused or aggravated Petitioner's condition. Thus, Petitioner's claim for benefits under 13 WC 5576 is denied.

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? (K)What temporary benefits are in dispute? TTD , and (N) Is Respondent due any credit?

The Arbitrator finds that Petitioner received reasonable and necessary medical treatment under claim 08 WC 56095, and TTD was properly paid, for which the Respondent receives a credit for payments made.

However, under claim 13 WC 5576, as Petitioner failed to prove accident and causation under the Act, the Respondent is due a credit for all TTD and maintenance benefits paid under this claim.

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

SEAN VINCENT JEFFERIES,
Petitioner,
vs.

NO: 14 WC 29797
18IWCC0398

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 causation, medical expenses, prospective medical treatment, 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 2, 2016 is hereby affirmed and adopted.

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

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

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

DATED: JUN 20 2018

Charles J. DeVriendt

CJD/rlc
o042518
049

Joshua D. Luskin

E. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JEFFRIES, SEAN
Employee/Petitioner

Case# **14WC029797**

CITY OF CHICAGO
Employer/Respondent

18IWCC0398

On 8/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1747 SEIDMAN MARGULIS & FAIRMAN
STEVEN J SEIDMAN
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

0010 CITY OF CHICAGO LAW DEPT
ELIZABETH MANNION
30 N LASALLE ST 8TH FL
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

Sean Jeffries
Employee/Petitioner

v.

18IWCC0398

Case # 14 WC 29797

Consolidated cases:

City of Chicago
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 **Kurt Carlson** Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **April 7, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
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

18IWCC0398

On **8/25/14**, 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 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 **8/25/14** injury, Petitioner earned $**70,408.00**; the average weekly wage was $**1,354.00.**

On the date of the **8/25/14** accident, Petitioner was **52** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00.**

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

PETITIONER'S CLAIM FOR BENEFITS IS DENIED.

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

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

Signature of Arbitrator

8-2-16
Date

AUG 2 - 2016

Sean Jeffries v. City of Chicago
14 WC 29797

FINDINGS OF FACT:

Petitioner claims a third at-work incident that occurred on Monday, August 25, 2014. Petitioner testified he had reinstated at work the end of the week prior to this date. Per Arbitrator's Exhibit 2, and the testimony of Ms. Marisol Santiago, Petitioner reinstated on or about Friday, August 22, 2014. At his reinstatement from his prior work injury under 13 WC 5576, Petitioner did not request time off for any unrelated medical conditions. (Tr. 46). The day following Petitioner's unwitnessed work incident, Petitioner underwent cataracts surgery. (Rx 18). Petitioner knew he had cataracts surgery scheduled for August 26, 2014, and had undergone pre-op testing. (Tr. 61). He had not reported this scheduled surgery to the HR Department when he was reinstated. (Tr. 61). He did not report it to his foreman/supervisor Mr. Norman Clark upon his return to work, stating he did not see his supervisor so he was unable to do so. (Tr. 62). Petitioner did not report the scheduled surgery following his incident. (Tr. 139, 142). Despite Petitioner's claimed work injury, he underwent cataracts surgery the next day on August 27, 2014, which his employer was unaware of.

On Monday, August 25, 2014, Petitioner reported an at work accident. When asked on cross-examination whether anyone witnessed the injury, Petitioner testified, "I would say the crew witnessed it." (Tr. 47). When presented with the Report of Occupational Injury for that date, Petitioner admitted he reported no witnessed. (Tr. 48). Petitioner reported on the Report of Occupational Injury that he was "getting gas for truck felt pain left ankle as I was climbing on truck, left ankle gave out injured left and right knee and ankle on falling to the ground." (Rx 9).

At the hearing, Petitioner's testimony as to the incident was "As I stepped on the steps, my left ankle gave out on me and I fell." He continued, "...when my left ankle gave out on me, I fell straight down, straight down right by the truck steps. And then I tried to pull myself up again, and I felt this sharp pain going through my left ankle. I got light-headed, I got dizzy, and then I fell off the truck and I landed on the concrete partition that holds the gas tanks." (Tr. 24).

This detailed account of the mechanism of injury was void from the account reported to Dr. Pye on the date of incident. Petitioner reported to Dr. Pye that same day the following:

> "...he was attempting to climb up on his tendon construct [sic] and he felt his left ankle give out. He states he lost his balance and felt a sharp pain in his left ankle. He states the accident happened so fast he is unable to remember the exact mechanism of injury. He stated he struck his knees on the vehicle as he attempted to regain his balance." (Px 9).

Dr. Pye noted Petitioner's pre-existing osteochondral lesions in both the right and left talar dome. Dr. Pye diagnosed Petitioner with ankle sprain and strain, osteochondral dissecans, lumbar sprain and strain, and contusion of knee, placed Petitioner on sedentary duty, and recommended physical therapy. (Px 9).

Petitioner did not return to his treater Dr. Lee, who he treated with previously for his left ankle. At the Arbitration hearing, he did not recall why he did not return to see Dr. Lee. (Tr. 52). Medical records from University of Illinois that pre-date the August 25, 2014 incident, show Petitioner treating for bilateral ankle pain. On April 23, 2014, Petitioner advised his treater at University of Illinois that his right side had been acting up for approximately the last six months. (Rx 18). He declined any surgeries at that time. (Rx 18). On July 31, 2014, Petitioner returned to University of Illinois for bilateral ankle pain. Petitioner only testified to and the medical records confirm the right ankle was not injured in the prior two work accidents. Petitioner has degenerative arthritis in both ankles in addition to the bilateral osteochondral defects. (Px 15-A).

Petitioner chose to treat with Dr. Howard Freedberg, an orthopedic surgeon at Suburban Orthopedics. Petitioner first saw Dr. Freedberg on September 23, 2014. The medical records from that report "the patient states he was getting into his truck, and his left ankle gave out on him. He started getting really sharp pains in both ankles, lost his balance and fell backwards onto the ground." (Px 11, Freedberg Dep. Exh. 2). In his deposition, when asked on cross-examination if "So do you recall how Mr. Jeffries or did he tell you how he was getting into his truck?", Dr. Freedberg responded, "No. An quite frankly that's an irrelevant issue to me because as a medical clinician, I don't deal with the legal aspect." (Px 11, p. 25-26). Dr. Freedberg then stated Petitioner told him he fell backward and hit the ground, but injured his knees, neck, back, and ankles. (Id., p. 27-28). Dr. Freedburg was unable to articulate whether Petitioner hit his knees. (Id. p. 29).

Dr. Freedberg acknowledged the osteochondral dessicans were pre-existing, but in his opinion, they were exacerbated from the work incident. (Px 11, p. 12).On cross-examination, Dr. Freedberg performed right ankle arthroscopy with a synovectomy, tibial osteoplasty and excision of the osteochondral defect with microfracture on April 4, 2015. (Px 7).

Petitioner attended a repeat IME with Dr. Michael Pinzur at Loyola University Medical Center on March 6, 2015. Dr. Pinzur had previously evaluated Petitioner on August 9, 2013, and June 27, 2014. (Rx 15). In his March 6, 2015 IME report, Dr. Pinzur evaluated Petitioner rand reviewed the medical records and films, found Petitioner's episode of his left ankle giving way because of pain did not even cause a temporary aggravation or exacerbation of the condition. (Rx 15). The MRI performed after the claimed work incident showed no change in marrow edema, consistent with no new injury. (Rx 15, 3/6/15 Dr. Pinzur Report). Dr. Pinzur found no causal connection between the injuries and the incident of August 25, 2014, and Petitioner could be working at the same level at as his FCE. (Id.). In his deposition, Dr. Pinzur explained, that

following the incident after his initial return to work in August 2014 , the MRI showed no deterioration of the process. (Rx 16, Dr. Pinzur Dep., p. 20). Dr. Pinzur further testified that the mechanism of an ankle "giving out" is unclear, but people frequently use it in conjunction with describing pain. (Id., 21-22). Dr. Pinzur also opined as the April 2015 right ankle surgery was not related to the August 2014. (Id., p. 21). Dr. Pinzur further testified that Petitioner had similar x-ray findings in both ankles prior to his surgery in 2009. (Id., p. 26). Dr. Pinzur did not examine the right foot as Petitioner did not have complaints to his right ankle at the time of his IME, only the left ankle. However, his opinion as to the right ankle was based upon his review of medical records, the x-ray, and the lack of any pathology to suggest surgery on the right at the time he saw him. (Id., p. 14, 30).Dr. Pinzur examined the records and explained the nature of the orgin of the osteochondral lesions. Dr. Pinzur testified that Petitioner has the same lesion in the same place in both ankles, and "that's highly unlikely that it's trauma. It is very hard to injure both ankles in the same way." (Id., p. 17).

On November 25, 2014, Petitioner reported to the ER at University of Illinois with complaints of nausea and emesis for the week prior, and that he had fallen the day before when he was walking up a landing and felt ankle pain and right knee pain, and his right knee "gave out and twisted". (Rx 18).

Petitioner's supervisor/foreman, Mr. Norman Clark testified that a motor truck driver would never have a reason to be alone on the job. (Tr. 125). About four crew members would be with a motor truck driver at any given time. (Tr. 126). This includes when a motor truck driver is getting gas. (Tr. 126).

Mr. Clark testified that when his employees need to reach him to request time off for medical procedures or vacations days, they would be able to reach him on his work phone. (Tr. 126). There would be no reason to make the request in person. (Tr. 126-127). On the date of the alleged incident, Mr. Clark was Petitioner's immediate supervisor. (Tr. 128-129). Mr. Clark testified that if Petitioner wanted to take a vacation day or a sick day, the normal procedure at that time would be to call Mr. Clark, and he would say yes or no depending on his manpower. (Tr. 130).

Mr. Clark testified that the position of motor truck driver is one where the driver is assigned to a truck, he gets on the truck, and he checks the fluids. He waits for his crew, and the foreman will direct him where to go. (Tr. 122). As far as the actual job description itself, for Petitioner's Petitioner the driver would not actually be doing any lifting. (Tr. 122-123). Laborers on the truck do all the lifting including unloading and loading of cargo, plumbers do all the plumbing, engineers do all the digging, and the driver is just to make sure is fluids are checked and go where the foreman tells him to drive. (Tr. 123, 125). All of these positions are different job titles from "motor truck driver." There is no climbing of ladders involved. The only climbing involved is for the two steps that go into the cab, the height of which vary depending on the truck being

used. (Tr. 124). If something goes wrong with the equipment, such as changing a tire, it would be reported to the foreman, and Fleet Services would come out to take care of it. (Tr. 125).

On cross-examination, Mr. Clark testified that he had an opportunity to speak with Petitioner about the alleged August 2014 incident, and it is reflected in the incident report from that date. (Tr. 131-132). When questioned what Petitioner said to Mr. Clark when he reported the incident, Mr. Clark testified Petitioner came in his office and said "I twisted both of my ankles putting gas in my vehicle." Mr. Clark further testified,

> "I had looked down, and I saw that he was wearing gym shoes. And I mentioned you can't be wearing gym shoes. And I mentioned you can't be wearing gym shoes. That's probably why you twisted your ankle. And he chuckled a little bit. And I said you twisted both ankles? And he said yes. I said uh-oh. That's why I checked in this box further investigation suggested in here." (Tr. 133).

When questioned further why he thought further investigation was necessary, Mr. Clark testified that Petitioner's demeanor and actions at the time caused him to think further investigation was necessary, explaining, "It was the way he walked in the room…He didn't look injured. He chuckled at the time of this, like it was just hard to believe that he got hurt getting gas. And he said he twisted both ankles." (Tr. 134). Petitioner never told Mr. Clark he fell off the truck. (Tr. 134-135). Petitioner verbalized to Mr. Clark he injured himself climbing into the truck, and wrote something different on his accident report. (Tr. 135).

Mr. Clark observed Petitioner walked right up to him following the alleged incident, and said he twisted both his ankles with no pain in his facial features. He wasn't walking with a limp. He grinned. And he said there were no witnesses. (Tr. 137). Mr. Clark's evaluation that the claimed incident warranted further investigation was based on his discretion, judgment, and experience as foreman for the City of Chicago for 13 year. (Tr. 139-140).

Mr. Clark testified that if an employee was scheduled to have eye surgery, it would be important to relay to his foreman in advance. (Tr. 138-139). Mr. Clark further testified that the use of one's eyes is critical to the job of motor truck driver, and he would need to see a doctor's note or have a doctor's note turned in to his department for a return to work. (Tr. 139). Petitioner never notified Mr. Clark of his scheduled eye surgery. (Tr. 139).

Ms. Marisol Santiago, Director of Administration for the Water Department, also testified at the arbitration hearing. (Tr. 95). Ms. Santiago oversees the personnel, human resources and payroll division for the department. Ms. Santiago also handles reinstatements when an employee has been off for leave and supervises the team responsible for processing employee reinstatements. (Tr. 95). Ms. Santiago testified she is aware of Petitioner's case and oversaw the reinstatement handled by Tina DeSanto of her Department. (Tr. 97-98). She testified that Mr. Jeffries met with her office on a Friday for reinstatement, and the injury occurred that Monday. (Tr. 98). Mr.

Jeffries did not submit a request for time off for unrelated medical conditions at the time of his reinstatement. (Tr. 98-99). Ms. Santiago explained, if Petitioner had requested time off for a surgery that he had already scheduled, her office would have prepared a leave of absence packet and allowed him an opportunity to go to his doctor to advise the department what he needed to be off work, at which point Petitioner would have been placed on a disability leave of some sort, assuming he qualified. (Tr. 99). His job would not have been in any sort of jeopardy had he relayed the surgery he had scheduled. (Tr. 99). Ms. Santiago also confirmed that the protocol for requesting days off is to notify their immediate supervisor of the intention to request a day off, and the employee and the bureau supervisor foreman determine whether or not they are eligible for that time and if they can take it. (Tr. 99).

Motor truck drivers do not get sick days, but they can use vacation days for medical conditions. (Tr. 100). Ms. Santiago confirmed her office was never notified of the planned scheduled surgery of Petitioner's. Ms. Santiago confirmed a foreman can also be reached to request time off via telephone, which is most times how employees in the field contact their immediate supervisor. (Tr. 101).

Petitioner no longer works for the City of Chicago. He was terminated following a Human Resources Board Hearing on the matter. (Tr. 103).

Petitioner underwent an FCE on October 20, 2015, which found his functional capabilities to be at "medium physical demand level". However, Petitioner reported his occupation to be a "construction worker" which is considered "heavy physical demand level." (Px 4). Petitioner agreed that the positions of motor truck driver and construction laborer are fundamentally different. (Tr. 56).

On October 28, 2015, Petitioner followed up with Dr. Freedberg. Dr. Freedberg evaluated the FCE, and noted the Petitioner's position as a "construction worker" which would be "heavy physical demand level" per the FCE. (Px 2). Dr. Freedberg placed Petitioner at MMI per the FCE. (Id.). Petitioner testified he never reapplied for his former position after his release from Dr. Freedberg. (Tr. 57). He never contacted the City to find alternative employment either. (Tr. 56-57).

Petitioner met with Ms. Susan Entenberg of Rehabilitation Services Associates at the request of his counsel on November 21, 2015. (Tr. 63)(Px 12). Petitioner did not provide Ms. Entenberg did not review the City of Chicago's job description. (See Px 12). Ms. Entenberg notes the position as a "heavy duty." When questioned on cross-examination whether Petitioner told Ms. Entenberg his position was "heavy duty", Petitioner responded, "I might have." (Tr. 55). The Petitioner told Ms. Entenberg that in his duties as a motor truck driver, he "loads and unloads truck", "was lifting in excess of 100 pounds occasionally", was "climbing ladders", changing trailers, and disconnecting the fifth wheel" among other tasks. (Px 12, p. 3-4). All of these tasks are in direct

contradiction to Petitioner's City of Chicago job description entered into evidence, and the testimony of Petitioner's direct supervisor/foreman Mr. Norman Clark.

Petitioner presented job logs that he began submitting to receive unemployment benefits through the Illinois Department of Employment services. (Px 29). He testified he began looking for employment as of September 23, 2016. (Tr. 54). Petitioner testified he did not look for driver positions. (Tr. 54). His job logs show Petitioner applying to be a "driver" position at Summit Trucking on 4/23, " forklift" position on 3/31, and a "forklift operator" on 10/30. Petitioner testified he only applied to one job a day, primarily online, because "that's all the document will hold." (Tr.55).

The Respondent introduced surveillance footage and the testimony of Mr. Matthew Roemer, a licensed private investigator. (Tr. 76). Mr. Roemer observed and videotaped Petitioner over three separate days, approximately seven to eight hours each day. (Tr. 78). Mr. Jeffries was observed picking up trash alongside with other members outside a church. (Tr. 80-81). Mr. Jeffries also stood out on a corner with two other men from Kingdom Hall Church with signage, pamphets, and talking to passersby for approximately 2 hours. Petitioner was observed walking with a cane the majority of the time, although he did observe him without a cane at times. He also was observed carrying items (Tr. 83, 84, & 88).

Mr. Jeffries testified he has not worked since August 25, 2014. He admitted on cross-examination that he volunteers his time for Kingdom Hall Jehovah Witnesses. (Tr. 52-53). He assists "every other moth" to assist in cleaning, and a couple times a week, he volunteers to speak to people about his Church's beliefs. (Tr. 67).

Petitioner testified he is still under the permanent restrictions Dr. Freedberg gave him. (Tr. 32). Petitioner claims injury to his left and right ankles as result of claim 14 WC 29797.

CONCLUSIONS OF LAW:

Regarding (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; Regarding (F) Is Petitioner's current condition of ill-being causally related to the injury?; and Regarding (L) What is the nature and extent of the injury?

To be compensable under the Workers' Compensation Act, the injury complained of must be one "arising out of and in the course of the employment." Ill.Rev.Stat.1991, ch. 48, par. 138.2. The claimant has the burden of establishing both requirements. (*Castaneda v. Industrial Comm'n* (1983), 97 Ill.2d 338, 341, 73 Ill.Dec. 535, 454 N.E.2d 632.) An injury " 'arises out of' one's employment if its origin is in some risk connected with or incident to the employment, so that there is a causal connection between the employment and the accidental injury." *Jewel Cos. v. Industrial Comm'n* (1974), 57 Ill.2d 38, 40, 310 N.E.2d 12. "An injury is received in the course

of employment where it occurs within a period of employment, at a place where the worker may reasonably be in the performance of his duties, and while he is fulfilling those duties or engaged in something incidental thereto". *Scheffler Greenhouses, Inc. v. Industrial Comm'n* (1977), 66 Ill.2d 361, 367, 5 Ill.Dec. 854, 362 N.E.2d 325.

When determining the above issues the Arbitrator must carefully weigh all of the evidence presented. This includes the credibility and testimony of the petitioner. The weight of a witness's testimony depends upon that witness's personal credibility. Once the petitioner's credibility is questioned, the concept of truthfulness becomes critical.

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*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

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 than 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).

In the current case, Petitioner's testimony was not credible, thus the Arbitrator relies on the evidence submitted into evidence as well as the testimony of the credible witnesses, Mr. Norman Clark, Ms. Marisol Santiago, and Mr. Matthew Roemer for determination of this case.

Petitioner returned to work by release from his treater with restrictions from claim 13 WC 5576 after failing an FCE for lack of effort and unreliable pain reporting. When Petitioner was reinstated on Friday August 22, 2014, he did not report that he had a surgery schedule for August 26, 2014, which would require him to be off work longer. At arbitration hearing, he testified on cross-examination that he did not report it because he did not see his supervisor. Both Ms. Santiago and Mr. Clark testified independently at the hearing that the typical protocol is to call the foreman in advance to request time off. Petitioner then testified on re-direct that he did not want to cause any problems with his reinstatement, so he did not mention his surgery scheduled for after his return date. Ms. Santiago, the Director of Administration for the Water Department testified a request for unrelated medical reasons for additional time off would not have jeopardized his position in any way and could have been accommodated.

Petitioner reported this unwitnessed incident of Monday, August 25, 2014, six hours into his shift after reinstating the Friday before. Petitioner initially testified there were witnesses present. When he was shown the accident report that he completed on cross examination, he then admitted he reported no witnesses.

Per the testimony of Petitioner's supervisor/foreman, Mr. Norman Clark, Petitioner's reporting of the incident caused him to believe there were grounds for further investigation. Petitioner did not show any indications of pain when he reported the incident to his foreman, and Petitioner reported the incident smiling. Mr. Clark also noted Petitioner's claimed mechanism of injury appeared strange, in that he reported he twisted both ankles, but walked without a problem into his office. Finally, Mr. Clark noted Petitioner was not wearing the protocol footwear of steel-toed boots. Mr. Clark documented what Petitioner reported to him in an incident report.

Petitioner did not advise Mr. Clark of his scheduled cataracts surgery for the next day, August 26, 2014. Petitioner attended this surgery.

Petitioner's accounts of the incident are inconsistent among his reports to Mr. Clark, his incident report, Dr. Pye's office, and later Dr. Freedberg. This arbitrator notes that Dr. Freedberg admitted in his deposition that the mechanism of injury was not important to him in respect to the evaluation of the conditions/injuries Petitioner presented with.

Furthermore, Petitioner went on to receive right ankle surgery. The medical records presented from the earlier claims of 08 WC 56095 and 13 WC 5576 show a consistent accounting that Petitioner had a pre-existing osteochondral defect in his right ankle which was symptomatic, despite no earlier right ankle injury.

Petitioner claims he was unable to return to work as a result of his treatment. Petitioner then participated in an FCE on October 20, 2015. Petitioner reported his occupation to be a "construction worker" which is considered "heavy physical demand level." (Px 4). This reporting of his position is inaccurate, and reflects a different demand level. Per the FCE performed in the 13 WC 5576 case, the physical requirements of a motor truck driver are "medium" demand level, which Petitioner qualified at this time. Dr. Freedberg's records also reflect an inaccurate reporting of his job title as "construction worker" when Petitioner was placed at MMI on October 28, 2015.

Although Petitioner was terminated from the City on grounds litigated in a separate proceeding, Petitioner testified he never contacted the City to reapply for his old position or for an alternative position following his release at MMI status.

Additionally, this Arbitrator gives no weight to the report of Ms. Susan Entenberg of Rehabilitation Services Associates from her meeting with Petitioner on November 21, 2015Petitioner did not provide Ms. Entenberg did not review the City of Chicago's job description. Ms. Entenberg notes the position as a "heavy duty" and cites job duties directly contrary to the motor truck driver job description entered into evidence and the testimony of foreman Norman Clark. The Petitioner told Ms. Entenberg that in his duties as a motor truck driver, he "loads and unloads truck", "was lifting in excess of 100 pounds occasionally", was "climbing ladders", changing trailers, and disconnecting the fifth wheel" among other tasks. Mr.

Clark testified the job description, which only provides for occasional lifting and carrying up to 35 pounds, would not even apply to Petitioner's position, which involved no lifting, laborer/mechanical work, or climbing of ladders. The only climbing involved would be the steps into the truck.

Ms. Entenberg's evaluation of Petitioner's capabilities is heavily discounted, as it was based on inaccurate information and little investigation into the actual job description and duties of Petitioner as a motor truck driver. This Arbitrator further notes that Petitioner submitted logs showing he applied for positions after his MMI date that he claimed he was unable to do, such as driver and forklift operator. Petitioner volunteers his time and services at his church multiple times per week, although he remains unemployed.

Overall, the evidence does not support Petitioner's claim that an accident occurred arising out of and in the course of his employment on August 25, 2014. The arbitrator finds Petitioner's claim of the unwitnessed incident on August 25, 2014 to be not credible and not supported by the evidence. The medical reports support the indication of Petitioner's unwillingness to return to work on August 22, 2014 from his earlier accident, as evidenced by his failure of his FCE for inconsistent effort and unreliable pain reporting, but return to work by his treater Dr. Lee nonetheless. Additionally, Petitioner claimed an unwitnessed accident, followed up by a suspicious reporting, per the testimony of his supervisor. Petitioner's accounts of the accident are inconsistent, and his claimed efforts to return to work of any kind are marred by his inaccurate reporting of his job position and duties to his treater, Dr. Freedberg, the FCE administering personnel, and Ms. Susan Entenberg. Finally, Petitioner's failure to report his previously scheduled surgery to his employer for the date following his alleged accident to be unjustified.

As to causation, although Petitioner has failed to meet his burden proving accident, this Arbitrator notes that Petitioner's treatment for this claim, which primarily involves surgery to his right foot, is related to a pre-existing, unrelated condition.

Thus, Petitioner's claim for benefits is denied.

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

As Petitioner failed to meet his burden for accident and causation, the Petitioner's claim for benefits is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PASHA HUNT-GOLLIDAY,

Petitioner,

vs. NO: 06 WC 27109

COOK COUNTY FACILITIES,

Respondent.

18IWCC0399

DECISION AND OPINION ON REMAND

This matter comes before the Commission on Remand from the Appellate Court of Illinois, First District, *in Pasha Hunt-Golliday v. Illinois Workers' Compensation Comm'n, et. al* (*Cook County Department of Facilities Management*), 1-15-1709WC.

Background

Petitioner, a journeyman ironworker, sustained a left palm laceration from razor wire while climbing down a ladder. Her wound was sutured and she received a tetanus shot in her right shoulder. After her tetanus shot, her right arm began to swell and she had problems closing right hand. Petitioner then began treating with Dr. Preston Wolin for her right shoulder, was authorized off work and underwent physical therapy to her right shoulder. Dr. Wolin offered a favorable causal connection opinion with regard to her right shoulder condition and the tetanus shot she received following her left palm laceration injury, that her tetanus shot aggravated an underlying right shoulder condition. Following an MRI of the right shoulder she underwent a right shoulder bursectomy with Dr. Wolin on December 1, 2006. Petitioner underwent therapy at Athletico from December 5, 2006 through January 15, 2007. On January 17, 2007, she underwent an unrelated back surgery by Dr. Chang. She completed her shoulder therapy at Athletico from February 5, 2007 through May 14, 2007. She was last seen by Dr. Wolin on May 16, 2007 at which time Dr. Wolin noted Petitioner complained she was still having pain in the anterior aspect of the shoulder which was tender to touch, had grinding on the top of the shoulder, occasional throbbing of the

shoulder at night, and snapping in the neck. Dr. Wolin opined Petitioner was at maximum medical improvement (MMI) on May 16, 2007. Due to the unrelated low back condition, Petitioner did not return to work until July 7, 2007 and she was given a sedentary job doing data entry when she did return to work. Petitioner continued to work that light duty job, pursuant to her low back condition restrictions, through the date of the Arbitration hearing on January 27, 2011.

Following the February 18, 2011 decision of Arbitrator Kane, Respondent appealed the decision of the Arbitrator wherein he found Petitioner sustained accidental injuries arising out of and in course of her employment on February 20, 2006, that Petitioner was temporarily totally disabled for a period of 70-6/7 weeks, from February 21, 2006 through June 18, 2006, June 24, 2006 through July 6, 2007 at $898.13 per week, that Petitioner permanently lost 17.5% loss of use of the right arm under Section 8(e), that Respondent is entitled to credit of $14,848.00 for TTD paid, and a credit of $27,410.19 under Section 8(j). On review, Respondent raised issues of accident, causal connection, medical expenses, TTD, and nature and extent of her disability. On October 17, 2011, the Commission affirmed and adopted the Arbitrator's February 18, 2011 Decision. Neither party sought judicial review of the Commission's October 17, 2011 decision.

On September 5, 2012, within 30 months from the date of the Arbitrator's Decision, Petitioner filed a Petition for Review under Sections 19(h) and 8(a). Petitioner filed a Petition seeking penalties and attorneys' fees under Sections 19(k), 19(l) and Section 16 on October 10, 2012. A hearing on the Petitions was held before Commissioner Lamborn on October 24, 2012.

Petitioner sought judicial review of the Commission's June 19, 2014 Decision denying Petitioner's petitions for additional benefits pursuant to Sections 19(h) and 8(a) of the *Illinois Workers' Compensation Act* (Act), (820 ILCS 205/8(a), 19(h) (West 2012) specifically denying Petitioner's demand for an award of medical expenses, temporary total disability benefits (TTD), and increased disability finding Petitioner failed to prove a material increase in her disability since the date of Arbitration on January 27, 2011 and Petitioner failed to prove her current condition of ill-being is causally related to her work-related injury of February 20, 2006. Further, the Commission also denied Petitioner's Petition for Penalties and Attorneys' Fees under Sections 19(k), 19(l), and 16, finding that Respondent acted in an objectively reasonable manner under all of the existing circumstances.

On May 14, 2015, the Circuit Court of Cook County, Illinois, in *Pasha Hunt-Golliday v. Illinois Workers' Compensation Comm'n, et. al., (Cook County Department of Facilities Management),* 14 L 50533, affirmed the Commission Decision.

Remand Order

The Appellate Court affirmed that portion of the circuit court's order which confirmed the Commission's finding that the Petitioner failed to prove an increase in her disability and its consequent denial of her request for additional permanent partial disability (PPD) benefits; reversed that portion of the circuit court's order confirming the Commission's finding as to causation and its resulting denial of an award of medical expenses and additional TTD benefits; reversed that portion of the circuits court's order confirming the Commission denial of the Petitioner's petition for an award of penalties and attorney fees; reversed the Commission's finding

18IWCC0399

as to causation and that portion of its decision denying the Petitioner's request for an award of medical expenses and additional TTD benefits; vacated that portion of the Commission's decision which denied the Petitioner's petitioner for an award of penalties and attorney fees; and remanded this matter back to the Commission with directions to: (1) award the Petitioner the additional TTD benefits and medical expenses to which she is entitled; (2) order DFM to authorize and pay for an MR arthrogram as recommended by Dr. Preston Wolin; and (3) reconsider the Petitioner's petition for an award of penalties pursuant to Sections 19(k) and 19(l) of the Act and attorney fees pursuant to Section 16 in light of the Appellate court's findings as to causation, medical expenses, and TTD benefits.

TTD entitlement

Petitioner testified she received no TTD benefits or authorization for right shoulder medical care subsequent to March 1, 2012. (11/1/13 Transcript, p.17).

On April 27, 2012 Dr. Wolin submitted a form in support of the Petitioner's application for Cook County disability benefits in which he stated the Petitioner's then "current shoulder problem is related to her prior injury sustained on 2/20/06."

Petitioner's attorney wrote a demand letter for the payment of TTD addressed to the state's attorney on May 21, 2012.

Pursuant to the Appellate Court Order, the Commission awards Petitioner 33 weeks TTD representing the period from March 1, 2012 through the date of the Commission hearing on October 24, 2012.

Medical

Pursuant to the Appellate Court Order, the Commission awards Petitioner the reasonable cost of the MR arthrogram as recommended by Dr. Wolin and the reasonable medical bills related to the right shoulder treatment dated December 20, 2011 through the date of hearing on October 24, 2012 from the Center for Athletic Medicine, Ltd. and Athletico pursuant to Sections 8(a) and 8.2 of the Act. The Commission notes the medical bills contained in Petitioner's exhibit 6 were previously awarded in the Arbitration Decision.

Penalties pursuant to Sections 19(k), 19(l) and attorney fees pursuant to Section 16

Having reversed the Commission's finding as to causation, TTD and medical expenses, the Appellate court remanded the matter back to the Commission with directions to reconsider the claimant's petition for an award of penalties pursuant to Sections 19(k) and 19(l) and attorney fees pursuant to Section 16 of the Act.

> The standard for awarding penalties under section 19(*l*) differs from the standard for awarding penalties and attorney fees under sections 19(*k*) and 16. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 514-15, 702 N.E.2d 545, 552-53, 234 Ill. Dec. 205 (1998).

> Penalties under section 19(*l*) are in the nature of a late fee *Mechanical Devices v.Industrial Comm'n*, 344 Ill. App. 3d 752, 763, 800 N.E.2d 819, 828 (2003). and are "mandatory '[i]f the payment is late, for whatever reason, and the employer or its carrier cannot show adequate justification for the delay.'" *Jacobo v. Illinois Workers' Compensation Comm'n*, 2011 Il App (3d) 100807WC, ¶ 20, 959 N.E.2d 772, 355 Ill. Dec. 358 (quoting *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515, 702 N.E.2d 545, 552, 234 Ill. Dec. 205 (1998)). "The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness." *Id.* When benefits are withheld for 14 days or more, a rebuttable presumption of unreasonable delay exists. 820 ILCS 305/19(*l*) (West 2012). "The employer has the burden of justifying the delay, and the employer's [***8] justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified." *Jacobo*, 2011 IL App (3d) 100807WC, ¶ 20, 959 N.E.2d at 777-78. "The Commission's evaluation of the reasonableness of the employer's delay is a question of fact that will not be disturbed unless it is contrary to the manifest weight of the evidence." *Id.*
>
> The standard for awarding [**45] attorney fees under section 16 and penalties under section 19(k) of the Act is higher than the standard under section 19(l). Section 16 attorney fees and section 19(k) penalties are intended to address situations where there is not only delay, but the delay is deliberate or the result of bad faith or improper purpose. *Jacobo*, 2011 IL App (3d) 100807WC, ¶ 24. Additionally, while section 19(l) penalties are mandatory, the imposition of attorney fees under section 16 and penalties under section 19(k) is discretionary. *Jacobo*, 2011 IL App (3d) 100807WC, ¶ 24.

In reversing the Commission's decision regarding causation, the Appellate Court relied upon Dr. Wolin's causal connection opinion in the document he executed on April 27, 2012 despite the four-and one-half year gap in treatment since he released Petitioner in May 2007. In so doing, the Court shifted the burden of proof to Respondent to prove something other than the effects of the tetanus shot caused her condition of ill-being, holding, *inter alia* "the absence of any evidence that her continuing right shoulder pain was the result of any cause other than the effects of the tetanus shot which she received on the date of her work injury on February 20, 2005 leads us to conclude that the Commission's finding that the claimant's current condition of right shoulder ill being is not causally related to her work injury is against the manifest weight of the evidence."

The Appellate Court held a reading of the Commission's entire decision led the Court to "believe that the Commission denied the Petition for Penalties and Fees based on the conclusion that there is no causal connection between the claimant's current condition of ill-being and her work accident."

The Commission's finding regarding causal connection was, however, merely one factor the Commission considered when denying penalties and attorney's fees. The delay in payment of compensation by the employer in the subject case was reasonable for several reasons. There is no evidence in the record that Petitioner sought or was refused right shoulder treatment after she was

released at MMI in May 2007.

The Commission has denied benefits in other cases based upon gaps in treatment where Petitioner is seeking §8(a) benefits after an award. *c.f. Brown v. State of Illinois*, 17 IWCC 0431, knee replacement surgery denied *inter alia* based upon seven year gap in treatment; *Halters v. City of Chicago,* 13 IWCC 86, 19(h)/8(a) petitions for benefits denied *inter alia,* for right arm specifically based upon three year gap in treatment; *Payne v. City of Springfield, 11 IWCC 705,* Petitioner's §§19(h)/8(a) petitions denied based, *inter alia*, upon gap in treatment; *Evans v. J. A. House, Inc.*, 99 IIC 0378, Arbitration decision reversed, causal connection denied, *inter alia*, based on two-year gap in treatment; *Cattelino v. R.M. Sellergren & Associates*, 03 IIC 0248 Arbitrator decision reversed, causal connection denied, *inter alia*, based on two month gap in treatment and surveillance video. Therefore, it was not unreasonable for an employer to rely upon a four and one-half year gap in treatment to deny compensation and to question causal connection.

The Commission also relied upon Dr. Wolin's December 20, 2011 Progress Notes. This visit was Petitioner's first visit to Dr. Wolin since May 2007, when Dr. Wolin opined Petitioner was at MMI, four and one-half years earlier. Dr. Wolin's December 20, 2011 office note confirmed Dr. Chang wrote Petitioner's sole work restrictions in 2007. The history in Dr. Wolin's December 20, 2011 note documents "the patient states that she was improved following the surgery and was released at MMI in May of 2007…the patient is not taking any pain medication for her shoulder, but she is using ibuprofen 800 mg tid for her back. She is currently working light duty with no lifting greater than 25 lbs, no vibrating equipment, no excessive bending. **These restrictions were given by her back doctor."** (10/24/12 Arb.T, Px2, p. 14) (emphasis added)

Two days later on December 22, 2011, Dr. Wolin signed Petitioner's first right shoulder restrictions since she was released at MMI in May 2007 in a "To Whom It May Concern" letter. The Commission infers the work status letter was provided at Petitioner's request since there was (again) no mention of work restrictions in Dr. Wolin's December 20, 2011 office visit note.

Other earlier records also corroborated the fact that Petitioner had no physical restrictions when Dr. Wolin released Petitioner in May 2007. Dr. Wolin's May 16, 2007 office note documented Petitioner's physical examination on that day. Her physical examination confirmed the bilateral shoulder examination was exactly the same, with no restrictions in Petitioner's right shoulder noted at the time Dr. Wolin opined she was at MMI. The left shoulder and the right shoulder range of motion (ROM) showed 0/170 degrees Passive/active arc of elevation, 100 degrees Passive external rotation at 90 degrees abduction, and 60 degrees Passive internal rotation at 90 degrees of abduction with a negative impingement sign. Petitioner was released to follow-up "prn". Therefore, in the absence of any restrictions on physical examination, it was reasonable to infer Dr. Wolin did not assign restrictions when he released Petitioner at MMI.

Corroborating Dr. Wolin's physical examination were the Athletico S.O.A.P. Daily Progress Notes on May 4, 2007, under physician "Wolin" (as opposed to those from "Chang") which document: "S: The pt states has no pain. A: no pain with movement." The last typed report from Athletico to Dr. Wolin on May 14, 2007 confirm Petitioner voiced a subjective pain complaint, however, objective passive range of motion documented bilateral shoulders within functional limits of all directions. The Assessment section documented: "This patient has **great**

range of motion at this time and continues to subjectively complain of some right anterior shoulder pain with above head activities." (emphasis added) She was discharged for her right shoulder to a home exercise program, with no evidence of shoulder restrictions.

The Athletico therapy notes also confirm her back surgeon, Dr. Chang recommended 4-6 more weeks physical therapy on June 11, 2007 and Petitioner was not lifting at that time. She continued with therapy for her non-work related lumbar back condition through June 15, 2007. The S.O.A.P. notes document on June 15, 2007 she reported Dr. Chang assigned a 25-pound lifting restriction.

These entries are consistent with Dr. Wolin's office note on December 20, 2011 documenting that her restrictions were assigned by Petitioner's back doctor. Therefore, the Commission finds any reasonable employer would have inferred that Petitioner had no right shoulder restrictions when she returned to work after she was released for her back in July 2007.

The afore-enunciated reasons are not at odds with the Arbitrator's Decision regarding payment of TTD benefits because the Arbitrator noted that the record was silent regarding the Petitioner's right shoulder restrictions when Dr. Wolin declared her at MMI. The Commission inferred the Arbitrator's reference to Petitioner's previous restrictions on June 19, 2006, were made as an observation becuase those restrictions were assigned before her surgery and almost one year before the date Dr. Wolin declared her at MMI.

It appears that since the record was silent regarding Petitioner's work status at the time, the Arbitrator awarded benefits through the date Petitioner returned to work. At the time of the Sections 19(h) and 8(a) hearing, Dr. Wolin's office note clarified, however, that Petitioner's restrictions were assigned by the back doctor.

The Commission also previously enunciated several other factors regarding Petitioner's testimony that differed from the record, thus her credibility was at issue, i.e. Petitioner testified at the time of the section 19(h) hearing on Review that she was working that whole time in data entry under restrictions issued by Dr. Wolin. The Commission finds no evidence of any work restrictions authored by Dr. Wolin with regard to her right shoulder during that period of time.

Petitioner testified at the time of the Sections 19(h) and 8(a) hearing on Review that she continued to treat with Dr. Wolin for her right shoulder after the prior Arbitration hearing, however, there is no evidence in the record to support her testimony, again tainting Petitioner's credibility. The medical records tendered into evidence confirm Petitioner sought no medical care for her right shoulder from May 17, 2007 until December 20, 2011, a period of over four-and-a-half years.

Furthermore, Petitioner testified that on December 20, 2011 Dr. Wolin renewed her restrictions for her right shoulder, however, Dr. Wolin's office notes are silent regarding restrictions until he wrote the "To Whom It May Concern" on December 22, 2011 The "Plan" section in his December 20, 2011 office note states: "Given condition of back I do not believe the pt will be able to do PT at present. Therefore I have recommended an injection." After that appointment, in what appears to be at the request of Petitioner, Dr. Wolin issued the shoulder work restrictions that comport with

the same restrictions Petitioner was under for her lumbar back.

Upon further scrutiny, the Commission finds Respondent acted in an objectively reasonable manner under the circumstances and any reasonable employer would resist payment of compensation since there was no evidence Petitioner ever presented right shoulder restrictions to Respondent during the period after her release at MMI and Dr. Wolin's December 20, 2011 office note would lead to one conclusion only, the only restrictions Petitioner had prior to that visit were assigned by the back doctor.

In addition, Dr. Wolin's records included "Other Correspondence" confirming his office received "Att Rec Faxed" and Cook County Pension Fund documents on December 1, 2011 plus a Cook County Pension Fund Disability Claim form and Physician Statement on December 8, 2011, all prior to the Petitioner's office visit on December 20, 2011. (Px2, pp. 77-81) Dr. Wolin's office then received "Cook County BLANKS ORIGINALS" on December 20, 2011, the same day of the Petitioner's first office visit.

On December 20, 2011, Petitioner's chart under "Demographics" documented "This case has been in litigation since 2006 and the patient finally won her case and per attorney Polpeka (sic) okay to seek treatment." Although the Petitioner was awarded benefits through the day of the Arbitration hearing in May 2007, it is clear her attorney substituted his judgement for a Commission finding on causation for treatment to be rendered four and one-half years later. Although Petitioner retained her right to prove causation under §8(a), the law often requires more than a return visit to the doctor four and one-half years later to prove causation.

The relevance of the flurry of correspondence activity in Dr. Wolin's records in early December 2011, before Petitioner saw Dr. Wolin for the first time in more than four and one-half years, is clear from Dr. Wolin's notes. The Petitioner's non-work-related lumbar back condition was deteriorating further. In the December 20, 2011 office note, under the "Plan" section, Dr. Wolin notes Petitioner needs a second, lumbar surgery at that time. Dr. Wolin's Plan states: "Given the condition of (her) back I do not believe the pt will be able to do PT at present." On January 5, 2012 Petitioner called and reported "her back surgeon states that she is not safe for PT in her shoulder and she needs a lumbar surgery. She will keep us updated with her conditions." (Px2, p. 68)

Dr. Wolin's office also received an attorney letter on January 11, 2012. (Px2, p, 71) Thus it was reasonable to infer that Dr. Wolin was apprised of the circumstances related to Petitioner's second non-work related back surgery. Based on the all the evidence, the Commission finds Respondent's conduct was reasonable since it appeared Petitioner addressed her right shoulder condition and sought off-work restrictions from Dr. Wolin when it became obvious she was going to lose time from work for her non-work related lumbar back surgery.

On May 15, 2012, there were two messages documented. The first documented the Petitioner called and reported "she just had surgery on her back performed and now she said she wants her to begin pt. She will be going to Athletico in Hyde Park." The second message was authored by the physician's assistant documenting he gave Petitioner a prescription for P.T. (Px2, p. 67)

Since Petitioner reported she needed a second, non-work related, lumbar back surgery to Dr. Wolin's office on January 5, 2012, a surgery she had within the next couple of months, the employer would have every reason to suspect Petitioner's motivation in seeking workers' compensation benefits for right shoulder pain after the four and one-half year gap in treatment.

Based upon a review of the record as a whole, the Commission finds any reasonable person in the employer's position would have believed the delay for payment of benefits was justified, Respondent's conduct was reasonable under these circumstances and Petitioner is not entitled to penalties and attorneys' fees under Sections 19(k), 19(l) and/or Section 16. In so finding, the Commission relies upon the record as a whole including the Petitioner's credibility issues, Dr. Wolin's May 16, 2007 finding of maximum medical improvement with no documentation of any restriction on physical examination at the time he released her or in the physical therapy records, Dr. Wolin's office note dated December 20, 2011 confirming Petitioner's work restrictions in 2007 through the date of that office visit on December 20, 2011 were assigned by Petitioner's lumbar back surgeon, Dr. Chang, and the significant four-and-a-half years gap in treatment following that office visit during which time Petitioner sought no right shoulder medical treatment and worked in a sedentary capacity.

Therefore, the Commission declines to award penalties or attorney's fees under Sections 19(k), 19(l) or 16.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Respondent pay to Petitioner the sum of $898.13 for a period of 34 weeks, from March 1, 2012 through the date of the Commission hearing on October 24, 2012, 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 pay to Petitioner the for medical expenses incurred for the cost of the MR arthrogram and the reasonable medical bills related to the right shoulder treatment dated December 20, 2011 through the date of hearing on October 24, 2012 from the Center for Athletic Medicine, Ltd. and Athletico pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition under Sections 19(k), 19(l) and 16 is denied.

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.

"Every county, city, town, township, incorporated village, school district, body politic or municipal corporation against whom the Commission shall have rendered an award for the payment of money shall not be required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons." *820 ILCS*

18IWCC0399

305/19(f)(2). Therefore, no bond is required. The party commencing the 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 2018
KWL/bsd

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Randy Larson,
Petitioner,
vs.

NO: 15 WC 10160

Pace,
Respondent.

18IWCC0400

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 12, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 20 2018
o052418
DLG/mw
045

David L. Gore

Deborah Simpson

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LARSON, RANDY
Employee/Petitioner

Case# **15WC010160**

14WC024080

PACE
Employer/Respondent

18IWCC0400

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

If the Commission reviews this award, interest of 1.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

0075 POWER & CRONIN LTD
ELENA CINCIONE
900 COMMERCE DR SUITE 300
OAK BROOK, IL 60523

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

Randy Larson
Employee/Petitioner

v.

Pace
Employer/Respondent

Case # 15 WC 010160
14 WC 24080
Consolidated cases:

18IWCC0400

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Waukegan, Illinois**, on **10/24/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 18IWCC0400

On **1/30/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$47,132.80** ; the average weekly wage was **$906.40**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **$85,193.56** under Section 8(j) of the Act. Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $141.96, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

12/11/17
Date

ICArbDec p. 2

DEC 12 2017

18IWCC0400

FINDINGS OF FACTS:

Petitioner testified that on January 30, 2015, he was pre-tripping his bus when he slipped and injured his right shoulder. Petitioner provided that there was snow, grease and mud on the ground when he slipped. He indicated that he fell on his right side, the "whole body." Petitioner testified the records submitted show he was seen at Vista Health System on January 31, 2015 where his right shoulder was -x-rayed and he was returned to work.

On February 18, 2015, Petitioner presented to Dr. Bruce Summerville at the Illinois Bone and Joint Institute (IBJI). Petitioner had previously treated at IBJI for a variety of unrelated orthopedic injuries. Petitioner reported right shoulder pain after falling at work, putting his arm out to catch his fall. An examination revealed tenderness with forward elevation and abduction. His impingement was positive and the crossover and SLAP was negative. Rotator cuff strength was 5-/5. Dr. Summerville noted the x-rays taken at Vista Health System on January 31, 2015 revealed no fractures or dislocation of the right shoulder. There were no degenerative changes. Dr. Summerville assessed right shoulder sprain and administered a corticosteroid injection. The doctor felt Petitioner appeared to have posttraumatic burisitis indicating that if Petitioner did not respond a MRI would be considered. Petitioner was returned to unrestricted work and instructed him to follow-up in three (3) weeks. (PX 6)

Petitioner returned to IBJI on four (4) occasions between April 2015 and July 2015, including two with Dr. Summerville, for unrelated cervical, lumbar and left knee conditions. During that period Petitioner underwent physical therapy and cervical epidural injections. Petitioner did not report shoulder complaints. (PX 6)

Petitioner testified that on August 16, 2015, he was involved in an accident while riding his Harley Davidson motorcycle. Petitioner testified that he was driving very slowly, about 3-5 miles per hour. Petitioner stated that in a effort to avoid hitting another car crossing in front of him, he hit his brakes and laid his motorcycle down on his right side. Petitioner testified that his right foot and ankle was underneath the motorcycle which according to Petitioner was the "biggest bike you can have."

On August 17, 2015 Petitioner returned to Dr. Summerville complaining right ankle, knee and shoulder pain. Dr. Summerville's record show Petitioner was involved in a motor vehicle accident while riding his motor cycle. It was noted Petitioner "dropped the bike landing on his right side…" Petitioner reported acute onset of pain the right knee, shoulder, and ankle. Petitioner's right shoulder examination revealed forward elevation and abduction 170 degrees, external rotation was 50 degrees and internal rotation was T10. Provocative tests for impingement, crossover and SLAP were all negative. Petitioner was assessed with nondisplaced right navicular fracture in the extraarticular portion. (PX 6) Petitioner testified that he experienced an increase in right shoulder pain after the accident, but after 3 to 4 days his right shoulder returned to its base-line.

Petitioner's testimony and the medical records submitted show Petitioner received no treatment to his right shoulder immediately following the August 16, 2015 motorcycle accident. He returned for treatment to IBJI for his ankle and left knee through October 2015. On October 15, 2015, Petitioner returned to Dr. Summerville with unrelated left knee complaints and "ongoing right shoulder pain." Dr. Summerville assessed right shoulder strain, possible rotator cuff tear. A MRI was ordered and completed that same day. The MRI demonstrated a low grade partial thickness tear of the bursal surface of the supraspinatus tendon. (PX 6)

Petitioner returned to Dr. Summerville on October 22, 2015. The doctor noted the MRI did not reveal a full thickness rotator cuff tear. The doctor continued his assessment of right shoulder sprain and administered an injection to the right shoulder. In his notes the doctor recorded, "As it relates to his shoulder and the fall at work in January, I believe he has sustained a sprain which because of persistent pain he subsequently developed stiffness in the shoulder, but no underlying fracture, dislocation or any permanent soft tissue injury." (PX 6)

On November 12, 2015, Petitioner returned to Dr. Summerville. The doctor noted the corticosteroid injection only provided 1-2 weeks of relief. Petitioner's pain had returned and he had pain with overhead motion. Dr. Summerville reviewed the previous MRI indicating he was suspicious of a small full-thickness rotator cuff tear. The doctor ordered an MRI arthrogram and administered another injection. (PX 6) Petitioner underwent the recommended MRI arthrogram on November 18, 2015. The indication was for "right shoulder pain. Injury 2 months ago. Unresponsive to cortisone injection." The arthogram showed a full thickness tear of the supraspinatus tendon. (PX 6)

On December 10, 2015, Dr. Summerville prescribed surgery. The doctor recorded his opinion that because Petitioner lacked any past significant complaints regarding the right shoulder, he believed Petitioner sustained a work related traumatic full thickness rotator cuff tear. The doctor noted that after reviewing the non-contrast study in March there was some abnormality suspicious for full thickness tear. Dr. Summerville assessed post-traumatic full thickness rotator cuff tear. (PX 6)

On December 21, 2015, Dr. Summerville preformed a right shoulder arthroscopy and subacromial decompression and rotator cuff repair. Petitioner's post surgery treatment was uneventful. He underwent post-surgical physical therapy from December 31, 2015 to March 29, 2016. Dr. Summerville placed a total work restriction on Petitioner during this period. Petitioner was seen in follow-up on May 12, 2016 and August 9, 2016, at which time he was discharged at MMI. (PX 6)

At Respondent's request, Petitioner presented for a Section 12 examination with Dr. Thomas Gleason on June 21, 2016. Pursuant to that examination Dr. Gleason prepared a report with his findings. The parties deposed him on May 23, 2017. (RX 1) He testified to the examination of Petitioner that he performed, his findings, and his opinions. Dr. Gleason testified that Petitioner's current right shoulder condition of ill-being was not causally related to the fall at work on January 30, 2015. The doctor instead related Petitioner's right shoulder condition to the motor cycle accident on August 16, 2015. The doctor stated that Petitioner's right shoulder condition was exacerbated by the motorcycle accident and that said accident caused increased pain in Petitioner's right shoulder. (RX 1, pp. 21-23) Specifically, Dr. Gleason found the November 18, 2015 arthrogram to be instructive in that it noted "minimal retraction" of the tendon. (RX 1, p. 19) Dr. Gleason noted that because the arthrogram showed minimal retraction, it meant the tear was recent, within the last three months. (RX 1, p. 20) Furthermore, the doctor noted Petitioner commented that he felt increased pain in his right shoulder after the motorcycle accident. (RX 1, p. 22) Dr. Gleason opined that the February 18, 2015 clinical findings of Dr. Summerville were not consistent with the findings reflected on the November 18, 2015 MRI study. The doctor stated his belief that that the November 2015 findings were not present in February 2015. Dr. Gleason stated, "I don't think that the clinical findings in February of 2015 were reflected in the MR arthrogram performed in November, as of which time he reported ongoing shoulder pain for two months. It seems to me like we have two separate situations here." (RX 1, pp. 28-29)

Dr. Summerville was also deposed in this matter. Dr. Summerville testified that Petitioner's motorcycle accident of August 16, 2015 represented a temporary aggravation only of his right shoulder condition. Dr. Summerville testified that the MRI of October 15, 2015 and arthrogram of November 18, 2015, and the initial February 18, 2015 clinical examination were all consistent and causally related to the January 30, 2015 work accident, necessitating that December 21, 2015 surgery. (PX 7, pp. 13-14) Dr. Summerville testified that

because of Petitioner's age, he more likely than not had some underlying subclinical asymptomatic tendinitis and the mechanism of injury was sufficient to accelerate the underlying disease to result in a full thickness rotator cuff tear. (PX 7, p.19) Dr. Summerville stated that the effects of Petitioner's description of the motorcycle accident "...was simply a temporary aggravation of an underlying pre-existing full thickness rotator cuff tear and was not sufficient biomechanical nature to result in the tear or worsen the tear in size in and of itself." (PX 7, p.21)

Petitioner testified that he has had no other injuries to his right shoulder, Petitioner testified that he continues to have pain, and numbness on lifting and carrying objects, pulling and reaching overhead. Petitioner testified that he retired from Respondent on July 7, 2017.

With regard to (F) Is Petitioner's current condition of ill-being causally related to the work accident, the Arbitrator finds the following:

Based on the testimony and evidence submitted, the Arbitrator finds that Petitioner's current right shoulder condition of ill-being is not causally related to the work accident.

The Arbitrator finds particularly persuasive the medical records documenting Petitioner's medical treatment. On February 18, 2015, Petitioner presented to Dr. Summerville reporting right shoulder pain after falling at work. Dr. Summerville assessed right shoulder sprain and administered a corticosteroid injection. The doctor felt Petitioner appeared to have posttraumatic burisitis, returned him to unrestricted work and instructed to follow-up in three (3) weeks. Petitioner did not return to Dr. Summerville for any right shoulder complaints until the motorcycle accident on August 16, 2015. During that period Petitioner was seen at IBJI on four (4) occasions between April 2015 and July 2015, including two with Dr. Summerville, for unrelated cervical, lumbar and left knee conditions. Petitioner did not report shoulder complaints. It was not until after the motorcycle accident in August 2015 that Petitioner began complaining of an increased right shoulder pain.

The Arbitrator finds Dr. Gleason's opinion regarding the timeline for the rotator cuff injury persuasive. He explained that when an MRI arthrogram shows minimal retraction of the tendon, the tear must have been recent. Specifically, Dr. Gleason found the November 18, 2015 arthrogram to be instructive in that it noted "minimal retraction" of the tendon. Furthermore, the doctor noted Petitioner commented that he felt increased pain in his right shoulder after the motorcycle accident. The Arbitrator is persuaded by Dr. Gleason's testimony that the November 2015 findings were not present in February 2015. Dr. Gleason stated, "I don't think that the clinical findings in February of 2015 were reflected in the MR arthrogram performed in November, as of which time he reported ongoing shoulder pain for two months. It seems to me like we have two separate situations here."

Based on the above, the Arbitrator finds that the motorcycle accident occurring on August 16, 2015 broke the causal connection chain and as such, Petitioner failed to prove that a causal relationship exists between his current right shoulder condition of ill-being and the work accident sustained on January 30, 2015.

With respect to J.) whether the medical services provided to Petitioner were reasonable and necessary, and whether Respondent paid all appropriate reasonable and necessary medical costs, the Arbitrator finds as follows:

The Arbitrator adopts his findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them by reference herein.

Based on the Arbitrator's findings regarding causation, the Arbitrator awards the medical expenses associated with Vista Health Systems for the January 31, 2015 treatment as well as the February 18, 2015 visit and treatment of Dr. Summerville. All remaining 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

MARIAH MADDUX,

Petitioner,

vs. No: 15 WC 28741

UNITED AIRLINES, INC.,

18IWCC0401

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, and 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 16, 2016, is hereby affirmed and adopted.

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

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

The party commencing the 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 0 2018

Joshua D. Luskin

Kevin W. Lamborn

CJD/dmm
O: 052318
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DISSENT AND PARTIAL CONCURRENCE

I must respectfully dissent from the majority's decision that the Petitioner failed to prove accident, and that her current condition of ill-being was therefore not causally connected to the accident on May 19, 2015. I would instead find accident and causation and find that Petitioner did prove she suffered from an injury to her right leg, right wrist, lumbar spine, cervical spine, left hip and left shoulder. I would further find Petitioner is entitled to reasonable medical expenses, temporary total disability benefits, and a remand to the Arbitrator for a determination of further benefits. However, I concur with the majority regarding the denial of penalties and fees.

Petitioner was employed by Respondent as a flight attendant and was in the middle of a multiple day trip on May 19, 2015. After landing in Newark, New Jersey, and checking in to the Respondent-mandated hotel, Petitioner retrieved her dinner from the lobby. While returning to her room to eat her dinner, Petitioner fell in the hotel hallway. Petitioner was a traveling employee at the time of her injury. She was in the course of a work-related trip, staying at a hotel paid for by her employer, and it was reasonably foreseeable she would have dinner, and was provided a daily stipend by her employer for her to be able to do so. Petitioner completed the remainder of her trip before seeking medical attention. During her testimony at trial, she testified to a defect in the carpeted floor. She was walking and carrying a box that obstructed her vision.

The Arbitrator should be reversed regarding accident. The determination of whether an injury suffered by a traveling employee, such as the Petitioner in this case, arose out of and in the course of her employment is governed by different rules than are applicable to other employees. *Nee v. Ill. Workers' Comp. Comm'n*, 2015 IL App (1st) 132609WC *citing Hoffman v. Industrial Comm'n,* 109 Ill.2d 194, 199 (1985). However, the fact that Petitioner is a traveling employee does not relieve her of the burden of proving that her injury arose out of her employment. *Hoffman*, 109 Ill.2d at 199. In *Venture-Newberg-Perini v. Ill. Workers' Comp. Comm'n* 2013 IL 115728 (2013), the Court looked to *Wright v. Industrial Comm'n*, 62 Ill.2d 65 (1975) for the appropriate analysis regarding a traveling employee. If a traveling employee is injured, the court then considers whether the employee's activity was compensable. In *Wright v. Industrial Comm'n,* 62 Ill.2d 65, 69 (1975), the court found that injuries arising from three categories of acts are compensable: (1) acts the employer instructs the employee to perform; (2) acts which the employee has a common law or statutory duty to perform while performing duties for his employer; (3) acts which the employee might be reasonably expected to perform incident to his

assigned duties. The third category applies here. Considering the third category, the court has found that traveling employees may be compensated for injuries incurred while performing an act they were not specifically instructed to perform. The act, however, must have arisen out of and in the course of his employment. To make this determination, the court considers the reasonableness of the act and whether it might have reasonably been foreseen by the employer. In the instant case, it is reasonable and foreseeable that the Petitioner would have gotten dinner after arriving at the Respondent-mandated hotel after an evening flight, thus satisfying the third prong that her accident arose out of her employment. She was carrying a box of food back to her room when she "took a tumble" in the hall and rolled into the wall. Based on the above analysis, Petitioner's accident arose out of and in the course of her employment

Further, Petitioner's current condition of ill-being is causally connected to the May 19, 2015 accident. Petitioner has multiple complaints, including her right leg, right wrist, lumbar spine, cervical spine, left hip and left shoulder. She did not suffer from these issues prior to her fall, and has undergone extensive conservative treatment since her fall in the form of physical therapy, multiple doctor's visits, and injections. Although some of her condition appears to be based on a degenerative condition, she was asymptomatic prior to her fall, and her condition manifested post-May 19, 2015. Once Petitioner sought medical treatment, she was only released limited duty – a restriction Respondent would not accommodate. She was eventually completely taken off work and had not returned to work as of the date of the hearing on Arbitration. Respondent did not submit an independent medical exam report, or any other evidence at trial to refute the medical records and/or Petitioner's testimony that she did not suffer from any of these issues prior to her fall.

Based on the above, I would find that Petitioner sustained a compensable accident that arose out of and in the course of her employment and that she is entitled to reasonable and necessary medical expenses incurred as a result of the May 19, 2015 fall, temporary total disability from May 22, 2015 through March 28, 2016, and the matter remanded to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MADDUX, MARIAH
Employee/Petitioner

Case# **15WC028741**

UNITED AIRLINES INC
Employer/Respondent

18IWCC0401

On 8/16/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRIAN J McMANUS & ASSOC, LTD
MATTHEW J MURPHY
30 N LASALLE ST SUITE 2126
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL R SIMONES
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

18IWCC0401

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

MARIAH MADDUX,
Employee/Petitioner

Case # 15 WC 28741

v.

UNITED AIRLINES, 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 **STEVEN FRUTH**, Arbitrator of the Commission, in the city of **CHICAGO**, on **March 28, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

N. ☒ Is Respondent due any credit?

O. ☐ Other

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned $36,399.48; the average weekly wage was $699.99.

On the date of accident, Petitioner was 65 years of age, ***single*** with 0 dependent children.

Petitioner ***has not*** 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 TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $0.

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

ORDER

The Arbitrator finds that the Petitioner failed to prove that her accident did not arise out of and occur in the course of her employment by Respondent. Therefore, the Arbitrator denies petitioner's Application for Benefits.

The Arbitrator denies Petitioner's Petition for Penalties & Attorneys' Fees under§16, §19(k) and §19(l).

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 15, 2016
Date

AUG 16 2016

18IWCC0401

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***K:*** Is Petitioner entitled to any prospective medical care?; ***L:*** What temporary benefits are in dispute? TTD; ***M:*** Should penalties be imposed upon Respondent?; ***N:*** Is Respondent due any credit?

STATEMENT OF FACTS

Petitioner Mariah Maddux has been employed at United Airlines as a flight attendant for over 20 years, since 1995. She testified that she had never sustained injury to, or received treatment for, the parts of the body that were injured in her May 19, 2015 fall.

Petitioner testified that she was on layover in Newark, New Jersey and staying at the Renaissance Airport Hotel. Petitioner testified that she worked a flight from Las Vegas to Newark that morning. She was scheduled to work a flight to Dallas/Fort Worth on the following morning. When flying that route, Petitioner testified that Respondent United Airlines paid for flight crews to stay at a hotel in New Jersey. Petitioner testified that Respondent would only pay for the flight attendants to stay in a designated hotel, the Renaissance. Petitioner testified she was free to stay anywhere she pleased but at her own cost. Petitioner testified that some flight attendants stayed with friends and some rented "crash rooms" on layovers. On the date of the accident, May 19, 2015, Petitioner stayed at the Renaissance. Respondent paid for her stay.

After checking into the hotel, Petitioner went to her room and ordered food for delivery. She testified that the hotel did not allow outside restaurants to deliver directly to guest rooms and that she had to go down to the lobby to meet the delivery person.

Petitioner testified that she retrieved her food from the delivery person and went back to her room to eat her dinner. Petitioner took the elevator to the third floor, where she was staying. Upon exiting the elevator, Petitioner took a wrong turn. She turned around to head in the right direction. As she walked past the elevator bank, Petitioner "took a tumble", falling forward and rolling into the wall. She had immediate pain in her right leg, just below the knee.

Petitioner testified that the area where she fell was carpeted. She stated that it was not wet and that there was no obvious defect in the carpet. Petitioner stated that the carpet was not bunched up. She did indicate that there may have been a dip in the floor in the area. On cross-examination, she testified that the floor may have been on a

downgrade slope. Petitioner finally testified that she "took a tumble" and did not know the reason for her fall.

After Petitioner fell, she returned to her hotel room to eat her dinner. She testified that she took aspirin and iced her right leg. She stated that she called the front desk of the hotel to report her fall. She did not report anything wrong with the area where she fell. She was asked whether or not she wished to go to the hospital and she declined. She did not complete any accident reports that day.

The following day, Petitioner reported to work. She did not notify anyone at United Airlines that she fell at the hotel. She worked a flight to Dallas/Fort Worth and a second flight to Chicago. She returned to her home in Las Vegas on the evening of May 20, 2015. Petitioner was sore all over the next morning, but completed the flight to Dallas, and then to Chicago. She was afraid of being stuck in a city away from home while injured, so she completed the three day trip to Las Vegas.

On May 21, 2015, Petitioner reported her accident to Respondent via telephone to a supervisor, Ed Yost, located in Los Angeles. Petitioner's supervisor completed an accident report (RX #1). The report describes Petitioner's accident as "[R]eturning to room, took elevator to 3rd floor, turn to the wrong wing then turned around to go to my wing and tumbled in front of the elevators, rolled and hit the wall." Petitioner confirmed that the report contains the history of accident that she gave to the supervisor. RX #1 also notes Petitioner's Concentra Medical Centers May 22, 2015 diagnoses: right lower leg contusion, left shoulder strain, right wrist strain, left hip and thigh contusion, and c/t/l (cervical/thoracic/lumbar) strain.

In addition to the supervisor's report, Petitioner completed an Employee's Claim for Compensation/Report of Initial Treatment form (PX #1 & RX #2). The history of accident in that report notes, "[A]t Newark Renaissance Airport Hotel May 19, 2015 8:30 p.m. ordered food, went down to pick it up came back up via elevator to third floor (room 319) took wrong turn to room then turn back to elevator to go to next wing took a tumble in front of elevator fell and rolled into wall. Got up went to room got ice and elevated leg. Took aspirin."

Petitioner's accident report also contains a section where the Petitioner listed the parts of the body that were injured in the accident (RX #2). The report instructs the employee to be specific when describing the body parts that were injured. Petitioner completed the form, indicating "right leg – below knee." There is no note of any other body part being injured.

On May 22, 2015, Petitioner reported to Concentra in Henderson, Nevada (PX #1). Petitioner presented with pain in legs, her left shoulder, left hip/lower back, right wrist, and right ankle. She stated that the injuries occurred 2 days before and as a result of a fall at work. She complained of 5/10 wrist pain, 4/10 back pain, 4/10 hip pain, and 4/10 right leg pain. She had reduced wrist, shoulder, and hip range of motion. She had full range of motion in her back.

Petitioner was diagnosed with cervical, thoracic, and lumbar strains, a lower leg contusion, hip and thigh contusions, and a shoulder strain (PX #1). Petitioner was instructed to take medications, begin physical therapy, and return to work with restrictions. Petitioner testified that Respondent's flight attendants cannot work with restrictions and must be able to return to full duty in order to work.

Petitioner returned to Concentra with waxing and waning pain complaints through June 17, 2015. On June 3 Petitioner reported no relief from her first therapy session. Her examination was similar to the first exam, pain with limited range of motion. Her diagnoses remained unchanged. She reported that she was scheduled to return to work on June 5. On June 10 Petitioner reported improvement with her therapy. She reported that she was working transitional duty. She was given a work release with restrictions. On June 17, 2015 Pettioner reported 6/10 pain in her neck, mid-back, and lower back. She had continued limited range of motion due to pain. Petitioner did not return for scheduled follow up.

In addition to treatment at Concentra, Petitioner sought care with her primary care physician, Dr. James Gabroy (PX #2). Petitioner initially saw Dr. Gabroy for her injuries on May 29, 2015. She reported that she fell and complained of right knee pain. Dr. Gabroy's records are largely illegible. However, he noted a Toradol injection and that Petitioner was unable to work. Petitioner testified that prior to the accident she saw Dr. Gabroy on a monthly basis for other medical issues and stated that the May 29 visit had been already scheduled prior to her accident.

Dr. Gabroy noted that Petitioner was unable to work: June 15; July 2, 20, and July 31; August 4, 17, and 24; September 3 and 28; and October 5, 2015. Dr. Gabroy filled out Respondent's Absence Certificate form on October 23, 2015. He noted that she was off work due to injuries sustained in the accident since May 22. (PX #2) Dr. Gabroy's most recent United off work note kept Petitioner from returning to unrestricted work until January 3, 2016. Petitioner testified that he continues to restrict her activities through the present.

Petitioner sought care at St. Rose Dominican Hospital's Emergency Room (PX #3) on July 2, 2015, complaining of back and left lower extremity pain from a fall May 19, 2015. The attending physician noted that x-rays were negative. She was discharged with a diagnosis of back pain causing sciatica. She was prescribed medications and instructed to follow up on an outpatient basis.

Petitioner testified that Dr. Gabroy referred her to Dr. Jaswinder Grover of the Nevada Spine Clinic for her spine-related injuries. Petitioner first saw Dr. Grover on November 3, 2015 (PX #5). She reported that her condition began following "a fall while at work back in May of this year." On her Patient Information form she twice noted that she "fell in lobby of hotel". She also reported a history of 2 meniscus tears on February 20, 2015 and surgery.

Petitioner complained of low back pain, gluteal pain, left leg pain, neck pain, interscapular pain, left upper extremity pain, and numbness, tingling, and

paraesthesias. She reported 9/10 pain. She reported that she had been seen at Concentra and by Dr. Bassewitz. Dr. Grover noted that there was no significant medical history.

On exam Dr. Grover noted subtle, diffuse swelling in the legs. There was an equivocal positive straight-leg raise on the left. Dr. Grover noted weakness in the extensor halluces longus bilaterally and dysesthesias over the S1 dermatome. He ordered X-rays and MRIs of her cervical and lumbar spines. Dr. Grover diagnosed cervical and lumbar arthropathies. He also ordered physical therapy.

Petitioner returned to Dr. Grover on December1, 2015. He diagnosed L4-5 and L5-S1 discopathy, spinal stenosis, facet arthropathy, and cystic degeneration with mechanical and radicular symptoms, primarily affecting the left lower extremity. He also diagnosed C5-6 and C6-7 spondyloarthropathy with mechanical and radicular symptoms. He recommended a lumbar orthosis for mechanical support and MRIs of the left shoulder and left hip.

On December 1 Dr. Grover also recommended injections at the L4-5, L5-S1, C5-6, and C6-7 disc levels to treat Petitioner's persistent and significant symptoms. He also recommended an MRI of the left shoulder because of impingement signs. On December 2, 2015 Dr. William Baumgartl, a pain management specialist with Nevada Spine Clinic, examined Petitioner and recommended epidural steroid and block injections at L2-5. "If substantial short term pain relief is seen, the patient may become an appropriate candidate for radio-frequency lesioning at these levels." (PX #5)

Dr. Grover referred Petitioner to neurologist Dr. Chris Milford for EMGs and NCVs (PX #6). The cervical exam on January 20, 2015 noted bilateral C5,6 radiculopathy, acute-on-chronic, and mild bilateral carpal tunnel syndrome. The lumbar exam on January 27, 2015 demonstrated left L4-5 radiculopathy, acute-on-chronic, and right and L5-6 radiculopathy, acute-on-chronic, and mild axonal polyneuropathy.

Petitioner had a lumbar MRI on October 12, 2015. It apparently was on referral from Dr. Bassewitz. The MRI demonstrated spinal stenosis at L4-5 and L5-S1. There were Type 1 modic changes at the L4-5 endplate as well as multiple neural foraminal nerve root cysts.

At trial, Petitioner testified that she no longer felt pain in her right leg, below the knee. Her complaints revolved around the entire left side of her body. She testified that she wished to undergo injections recommended by her treating physician.

CONCLUSIONS OF LAW

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

Petitioner was on a flight layover while employed as a flight attendant by Respondent. She was lodged in a hotel paid directly by Respondent. After she took delivery of carry-out food in the hotel's lobby Petitioner fell after she stepped off the hotel elevator. She took a few steps in the wrong direction to go back to her room. As she turned to toward her room she fell and was injured.

Petitioner testified that she did not know what caused her to fall. She testified that there was no defect in the carpeting in the area where she fell. On direct-examination she said there may have been a "dip" in the floor. On cross-examination she testified that there may have been a slope in the floor where she fell. She did not say the she fell due a dip or slope in the floor. In the end, Petitioner did not explain what caused her fall.

The Arbitrator notes that Petitioner was not credible when testifying about the possibility of a dip or slope in the floor. Petitioner did not report to Respondent that she fell due to any defect. She did not report a cause of her fall to any of her treating physicians. In fact, she reported to Dr. Grover that she fell in the hotel's lobby. The testimony about a dip or slope in the floor outside the elevator appeared contrived.

While it is foreseeable that Petitioner would take a meal while on layover it is irrelevant that Petitioner may have been a travelling employee. This is clearly an unexplained accidental fall where there was no evidence that the fall was the result of an enhanced risk incidental to Petitioner's employment or that Petitioner was exposed to greater risk than the general public.

In addition, the Arbitrator notes that Petitioner completed her assigned duties as a flight attendant on the remainder of her assigned flights the day after she fell. She did not testify that her injuries prevented her from performing her job duties or that her ability to perform those duties was impaired due to her claimed injuries. This inconsistency also detracted from Petitioner's credibility.

Petitioner failed to prove that she sustained a compensable injury that arose out of her employment by Respondent.

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

In light of the Arbitrator's finding stated above that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent, this issue is moot.

K: Is Petitioner entitled to any prospective medical care?

In light of the Arbitrator's finding stated above that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent, this issue is moot.

L: What temporary benefits are in dispute? TTD

In light of the Arbitrator's finding stated above that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent, this issue is moot.

M: Should penalties be imposed upon Respondent?

In light of the Arbitrator's finding stated above that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent, this issue is moot. However, the Arbitrator does find that Respondent was not unreasonable or vexatious in denying payment of benefits, nor did Respondent assert a frivolous defense.

N: Is Respondent due any credit?

In light of the Arbitrator's finding stated above that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent, this issue is moot.

August 15, 2016

Steven J. Fruth, Arbitrator

ICArbDec p

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald D. Miller,

Petitioner,

vs.

NO: 16 WC 30152
16 WC 31259

CSI Manufacturing, Inc.,

Respondent.

18IWCC0402

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice provided to all parties, the Commission after considering the issues of causal relationship, medical expenses both incurred and prospective, and temporary total disability benefits, and being advised of the facts and the law modifies the Decision of the Arbitrator as stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of an amount of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

STATEMENT OF FACTS

Accident is not in dispute as Respondent did not appeal the arbitrator's finding. Petitioner testified he injured his lower back on May 24, 2016 when lifting a door weighing approximately 50 1bs. T. 17. Petitioner continued to work the remainder of the day. T. 18. Petitioner testified he continued to work his regular job and his pain progressed. T. 19. Petitioner testified he sought initial medical treatment four days following the injury on May 28, 2016 at Hammond-Henry Hospital. *Id.*

The medical records evidence Petitioner presented to Hammond-Henry Hospital emergency room on May 28, 2016 complaining of back pain with the onset approximately one-month prior with a re-injury a few days prior. Petitioner was diagnosed with back pain; provided Percocet; and advised to follow-up with his primary care physician, Dr. Rabacal. A CT scan was also undertaken which evidenced degenerative changes and no acute findings. PX1.

The medical records evidence Petitioner sought treatment from physician's assistant Heidi Vorac on May 31, 2016. PA Vorac diagnosed lower back pain and referred Petitioner to Dr. Berry. PX2.

The medical records evidence Petitioner sought treatment from Dr. Michael Berry on June 23, 2016. Petitioner provided a history of lifting a door weighing approximately 75 lbs. when he felt an immediate onset of pain in his lower back. Petitioner advised the pain was predominately located in his lower back but with some radiation to his left buttocks and hamstring region. Dr. Berry performed a physical examination and noted among other findings, "He had pain to very light palpitation across the lumbar region. This was an exaggerated pain response. Just brushing my hand causes significant withdrawal." Dr. Berry reviewed the CT scan performed on May 28, 2016 from Hammond-Henry Hospital and noted "Again, there is no sign of trauma, tumor, or infection. The bony anatomy reveals extensive multilevel degenerative changes without sign or acute pathology." Dr. Berry diagnosed an "acute exacerbation of low back with possible radicular symptoms" and recommended an MRI, physical therapy, and a return to work eight hours per day with lifting restrictions of ten pounds. PX3.

On July 7, 2016, an MRI was performed which evidenced multilevel degenerative disc disease, suggestion of an annular tear at L4-L5, and no disc herniations identified. On July 14, 2016, Dr. Berry re-evaluated Petitioner who continued to report mainly low back pain with discomfort into the hamstring but denied right extremity radicular complaints. Dr. Berry reviewed the MRI and noted "multi levels of essentially age-appropriate disk degeneration" and diagnosed "acute exacerbation of low back pain with left hamstring discomfort." Dr. Berry did not find Petitioner to be a surgical candidate and stated "Furthermore, the disk protrusion on the right at L4-L5 seems to clinically insignificant. The patient does not describe right-sided L5 symptomatology to me." Dr. Berry again recommended physical therapy, a return to work with a ten-pound lifting restriction, and a referral to Dr. Sundar. PX3.

The medical records evidence Petitioner commenced physical therapy on July 20, 2016 at Rock Valley Physical Therapy and discontinued treatment on September 7, 2016. The records evidence Petitioner attended therapy twice a week during which time his pain complaints waxed and waned. On August 3, 2016, the therapist noted Petitioner "still has muscle spasm and guarding to manual therapy and gentle touch." PX4.

The medical records evidence Petitioner sought treatment from Dr. Sundar on August 5, 2016 complaining of predominately low back pain. Dr. Sundar diagnosed cervical/lumbar stenosis, lumbar HNP with myelopathy, and lumbar facet syndrome. Dr. Sundar prescribed medications and recommended a series of epidural steroid injections. On August 23, 2016 Petitioner underwent the first injection which provided him 50% pain relief as reported to Dr. Sundar on September 6, 2016. Dr. Sundar recommended a second injection with was performed on September 20, 2016 which provided 25% pain relief until Petitioner's return to work. PX5.

On October 5, 2016 Dr. Sundar re-evaluated Petitioner who complained of increased pain since returning to work. At Petitioner's request, Dr. Sundar excused him from working. Petitioner further advised Dr. Sundar no further medical treatment would be authorized by Respondent. Dr. Sundar continued to provide care to Petitioner and recommended a diagnostic medial branch block and possible radiofrequency ablation due to the diagnosis of facet arthropathy. PX5. Petitioner testified he underwent the radiofrequency ablation a week prior to hearing. T. 28. Petitioner testified he has not returned to work since October 3, 2016. T. 27.

In the interim Petitioner was evaluated by Dr. Kern Singh on two occasions pursuant to Section 12 of the Act at Respondent's request, September 19, 2016 and November 21, 2016. On September 19, 2016, Petitioner provided a consistent history of accident with complaints of low back pain despite epidural steroid injections and physical therapy. Dr. Singh performed a physical examination which was normal. The examination also included Waddell testing which was positive in all five categories. Dr. Singh opined "It appears to me that the patient's complaints are nonanatomic in nature. They appear to be extremely magnified. He has extreme facial grimacing and grunting throughout his examination, which is inconsistent with his normal neurological examination." Dr. Singh diagnosed Petitioner with a resolve muscle strain; released Petitioner to return to work full duty; and placed Petitioner at maximum medical improvement. RX1.

On November 21, 2016, Petitioner complained his back pain increased after a return to work with a pain level of 8/10. Dr. Singh performed a physical examination which was again normal. The examination again included Waddell testing which was positive in all five categories. Dr. Singh noted "His pain complaints are excessive in nature an nonanatomic." Dr. Singh diagnosed a resolved muscle strain; released Petitioner to return to work full duty; and placed Petitioner at maximum medical improvement. Dr. Singh opined Petitioner's "current complaints are not causally related to either the May 24, 2016 or the October 3, 2016 injury." RX2.

CONCLUSIONS OF LAW

The Commission finds the Petitioner failed to prove a causal relationship between his accident of May 24, 2016 and his current condition of ill-being and need for treatment. "[T]he Commission is not bound by the arbitrator's findings and may properly determine the credibility

of witnesses, weigh their testimony and assess the weight to be given to the evidence. [citation omitted]." *R.A. Cullinan and Sons v. The Industrial Commission*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240 (1991). The "interpretation of the testimony of medical witnesses is particularly within the province of the Industrial Commission. [citation omitted]." *A.O. Smith Corporation v. The Industrial Commission*, 51 Ill. 2d 533, 537, 283 N.E.2d 875 (1972). The Commission modifies the Arbitrator's decision and finds Petitioner reached maximum medical improvement on September 19, 2016 and failed to prove a causal relationship for his current condition of ill-being thereafter based upon the opinions of Dr. Singh.

The Commission weighs the competing medical opinions of Dr. Singh and Dr. Sundar and affords greater weight to the opinions of Dr. Singh finding such opinions more persuasive. Moreover, Dr. Singh's opinions are supported by the findings of Dr. Berry, Petitioner's treating physician and the physical therapy notes. Dr. Singh in evaluating Petitioner on two occasions found Petitioner's physical examinations to be completely normal. Further, Dr. Singh found Petitioner's complaints of pain out of proportion to his physical examination and in a nonanatomic distribution. During both evaluations, the Waddell findings were positive in all five categories indicating symptom magnification. Dr. Berry noted the same symptom magnification during his initial evaluation of Petitioner noting "pain to very light palpation across the lumbar region. This was an exaggerated pain response." Further Dr. Berry in reviewing the MRI performed on July 7, 2016 opinioned such findings were "age-appropriate degeneration" and the disc protrusion evidence on the right-side did not correlate with Petitioner's pain complaints. Petitioner's exaggerated pain response was also documented in the physical therapy notes. Additionally, both diagnostic tests performed, CT scan and MRI found no acute pathology.

The Commission finds Dr. Singh's opinion that Petitioner suffered from a muscle strain which resolved on or about September 19, 2016 with a full duty release to return to work to be persuasive. The Commission further finds Petitioner suffered a temporary aggravation of his pain on October 3, 2016 which based upon Dr. Singh's opinion resolved on or about November 21, 2016.

Section 8(a) of the Illinois Workers' Compensation Act entitles a claimant to recover medical expenses which are reasonable, necessary, and causally related to an accident. *820 ILCS 305/8(a)* (West 2010); *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 418 N.E.2d 718 (1981). The same standard applies to prospective medical care. *Homebrite Ace Hardware v. The Industrial Commission*, 351 Ill. App. 3d 333, 814 N.E.2d 126 (2004). Petitioner sustained a back strain due to his accident of May 24, 2016 with maximum medical improvement being reached by September 19, 2016. As such all treatment following this date is neither reasonable nor necessary nor is it causally related to Petitioner's accident. The Commission vacates the award of prospective medical care as recommended by Dr. Sundar.

"To show entitlement to TTD benefits, claimant must prove not only that he did not work, but that he was unable to work. [citation omitted]." *City of Granite City v. The Industrial Commission*, 279 Ill. App. 3d 1087, 1090, 666 N.E.2d 827 (1996). Petitioner was released to full duty by Dr. Singh on September 19, 2016. As such, Petitioner was able to work but chose not to do so. Further "[t]he dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement. [citation omitted]." *Mechanical Devices v. The Industrial Commission*, 344 Ill. App. 3d 752, 759. Petitioner reached maximum medical improvement as of September 19, 2016 and then following his temporary aggravation of pain as of November 21, 2016. As such, no temporary total disability benefits are awarded beyond November 21, 2016. The award of temporary total disability benefits for the period of November 22, 2016 through February 7, 2017 is vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's June 15, 2017 decisions are modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $430.58 per week for a period of 17 weeks, from May 31, 2016 through September 26, 2016 based on the parties' stipulation, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act and as provided in §19(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $418.67 per week for a period of 7-5/7 weeks, from October 4, 2016 through November 26, 2016 based on the parties' stipulation, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act and as provided in §19(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the sum of $6,769.46 for reasonable, necessary and related medical expenses pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of prospective medical care is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes Respondent paid $10,129.22 in TTD benefits.

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired

18IWCC0402

without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 21 2018
LEC/maw
o04/11/18
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

MILLER, RONALD D
Employee/Petitioner

Case# **16WC030152**

16WC031259

CSI MANUFACTURING INC
Employer/Respondent

18IWCC0402

On 6/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% 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:

0294 KATZ NOWINSKI PC
THOMAS E CADY
1000 36TH AVE
MOLINE, IL 61265

0766 HENNESSY & ROACH PC
GUY N MARAS
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

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STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Ronald D. Miller
Employee/Petitioner

v.

CSI Manufacturing, Inc.
Employer/Respondent

Case # **16** WC **30152**

Consolidated cases: **16 WC 31259**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **2/7/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0402

FINDINGS

On the date of accident, **5/24/16**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$33,585.24**; the average weekly wage was **$645.87**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$10,129.22** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$10,129.22**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $6,769.46, as set forth in Petitioner's exhibits 6-11, 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 prospective medical care as recommended by Dr. Sundar, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $430.58/week for 16 6/7 weeks, commencing 5/31/16 through 9/26/16, and 18 1/7 weeks, commencing 10/4/16 through 2/7/17, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $10,129.22 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.

Michael K. Nowak, Arbitrator

5/31/17
Date

ICArbDec19(b)

JUN 15 2017

FINDINGS OF FACT

On 5/24/16 Petitioner was working as a Drywaller Finisher for Respondent at its company location in Cambridge, Illinois. His work included taping and mudding, sanding, applying texture sealant, climbing ladders and scaffolds, and lifting 60 to 70 pounds.

Petitioner candidly acknowledged having had prior bouts of low back which he categorized as pulled muscles. Treatment usually included medication, heat, and ice. He testified that he did not miss any work following any of the prior incidents involving his lower back.[1] On 4/25/16, he was sitting on a bucket in a van because there were no seats available. He complained of low back pain and sought medical treatment but did not miss any work.

On 5/24/16, Petitioner reported to work at around 6:30 AM and started his tasks at 7 AM. He indicated he was not experiencing any back pain when he arrived at work. He was unloading wooden doors that measured three feet by 72 inches without assistance. He testified that the doors each weighed around 50 pounds. The doors were not wrapped but did include framing. While setting the third door down, he noticed severe pain in his lower back. The Petitioner testified that he finished his shift but the pain became worse.

By the morning of Saturday, 5/28/16, the Petitioner testified that he was having trouble sleeping and standing. He sought treatment at Hammond-Henry Hospital where he was given pain killers. He was instructed to follow up with his primary care physician who referred him to an orthopedic surgeon, Dr. Berry. Dr. Berry determined that the Petitioner was not a surgical candidate but did refer him to a pain management specialist, Dr. Sundar.

Petitioner saw Dr. Sundar for the first time 8/5/16. In his office note of that date Dr. Sundar notes that Petitioner injured himself at work carrying a 75 pound door. Dr. Sundar further indicated that the work injury exacerbated Petitioner's pre-existing low grade chronic back pain significantly. Dr. Sundar recommended a series of lumbar epidural steroid injections with the first shot being performed on 8/23/16. Dr. Sundar also prescribed Gabapentin, Cyclobenzaprine, Meloxicam and Pantoprazole for Petitioner's low back pain. In a follow up visit to Dr. Sundar on 08/06/16 Petitioner indicated that the injection and medications had helped some, but he had weakness at times in the legs. Dr. Sundar planned another epidural steroid injection for 09/20/16. He also kept the Petitioner off of work.

On 9/19/16, the Petitioner saw Dr. Singh at Respondent's request pursuant to Section 12 of the Act. Dr. Singh opined that Petitioner had sustained a soft tissue muscular strain that had resolved. Dr. Singh released the Petitioner back to work full duty.

While awaiting the Dr. Singh's report Petitioner had the second epidural steroid injection with Dr. Sundar as scheduled on 9/20/16. When Dr. Singh's report became available Respondent terminated Petitioner's TTD benefits and indicated that they would pay for no further medical treatment.

---

[1] The Arbitrator notes that the medical records reflect Petitioner sustained a prior injury in the year 2000 for which he did apparently miss approximately 2 weeks of work.

As a result of the termination of benefits Petitioner attempted to return to work on 9/27/16. Petitioner testified he returned to his regular job and struggled for approximately five days. Petitioner indicated that while he attempted to do all aspects of his job, he would seek help when necessary and performed his tasks much more slowly. On 10/03/16 Petitioner was on a plank attempting to "mud" a ceiling, which he described as using a 10-12 foot pole with a roller on the end to apply plaster- like material to the ceiling. Petitioner testified that while performing this task he felt extreme pain in his low back that took him down to his knees. Respondent called an ambulance and Petitioner was taken to Hammond-Henry Hospital where he was told to follow up with his primary care doctor and Dr. Sundar.

On 10/15/16 Petitioner saw Dr. Sundar's PA who noted in an office note of that day that Petitioner had had a decrease in his pain following the two epidural steroid injections, but that since returning to work the low back pain has become much more severe. The PA noted that Petitioner's low back pain was worse on the right but that it radiated to the left thigh as pain, numbness and tingling. Petitioner was continued off of work.

Petitioner saw Dr. Sundar on 11/07/16 who noted that Petitioner was having difficulty walking one block without a cane due to low back pain. Dr. Sundar noted that Petitioner's primary pain generator remains the facet arthropathy, that Petitioner was not at maximum medical improvement and the Petitioner was a candidate for a diagnostic medial branch block and consideration for a radiofrequency ablation.

The Petitioner was reexamined pursuant to Section 12 by Dr. Singh on 11/21/16. Dr. Singh again released Petitioner back to work full duty.

At the time of hearing Petitioner testified that he had the radiofrequency nerve ablation procedure the week before the hearing and had provided him 30% relief. He remained under the care of Dr. Sundar. Dr. Sundar had continued to keep Petitioner off work from 10/3/16 through the date of hearing.

CONCLUSIONS

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

Petitioner was working as a Drywall Finisher for Respondent on 5/24/16. Petitioner testified that he was unloading wooden doors that each weighed approximately 50 pounds. He testified that while setting the third door down, he noticed pain in his lower back. Respondent did not submit any evidence to the contrary.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds Petitioner has satisfied his burden in establishing that on 5/24/16, he sustained an accident arising out of and in the course of his employment.

After Respondent terminated benefits on 9/26/16 Petitioner attempted to return to work without restriction. On 10/3/16 Petitioner was on an elevated plank "mudding" a ceiling. Petitioner testified that "mudding" consisted of using a 10-12 foot pole with a roller on one end to apply texture to the ceiling. Petitioner testified that after the roller was dipped in the texture, the pole, roller and texture weighed approximately 25-30 pounds. Petitioner testified that he had had lifted the pole towards the ceiling when he felt

extreme pain in his low back that brought him to his knees. He was taken from the scene by ambulance. Respondent did not submit any evidence to the contrary.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds Petitioner has satisfied his burden in establishing that on 10/3/16, he sustained an accident arising out of and in the course of his employment.

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

The Arbitrator found Petitioner to be a credible witness. Petitioner candidly admitted he had experienced back pain intermittently in the past. He testified that he had always gone back to work following those preexisting low back episodes and was always able to perform all aspects of his physically demanding job with Respondent. Respondent offered no evidence to the contrary.

Dr. Sundar is a pain management specialist and Petitioner's primary treating physician. Dr. Sundar specifically wrote in his record of 08/05/16 "I do believe that the work-related incident to a reasonable degree of medical certainty did exacerbate his pre-existing low grade chronic back pain significantly." Dr. Sundar prescribed a series of epidural steroid injections which provided Petitioner some relief. Dr. Singh opined that Petitioner had a soft tissue strain which had resolved. He indicated Petitioner was able to return to work full duty and required no additional medical treatment. The Arbitrator finds the opinions of Dr Sundar more persuasive than those of Dr. Singh in this case.

Although Petitioner did experience an increase in his back pain on 10/3/16 the evidence in the record fails to indicate any permanent increase Petitioner's symptoms following the attempted return to work.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition of ill-being is causally related to the accident of 5/24/16. As set forth below, benefits are awarded in 16 WC 30152. The Arbitrator further finds that the accident of 10/3/16 resulted only in a transient exacerbation of Petitioner's symptoms and his current condition of ill-being is not causally related to the accident of 10/3/16. Benefits are therefore denied in 16 WC 31259.

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?

Petitioner submitted medical expenses totaling $6,769.46 (PX 6-11). Having found in favor of Petitioner with regard to the issues of accident and causal connection, and further having found the opinions of Dr. Sundar more persuasive than those of Dr. Singh, the Arbitrator finds Petitioner's submitted medical expenses are related to reasonable and necessary medical treatment as a result of Petitioner's injuries. The Arbitrator further finds Petitioner is entitled to prospective medical care.

Respondent shall pay reasonable and necessary medical services of $6,769.46, as set forth in Petitioner's exhibits 6-11, 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 further authorize and pay for prospective medical care as recommended by Dr. Sundar, as provided in Sections 8(a) and 8.2 of the Act.

Issue (L): What temporary benefits are in dispute?

The parties stipulated that Respondent paid TTD benefits from 5/31/1616 through 9/26/16 when Petitioner attempted to return to work for Respondent. The parties further stipulated that Respondent paid TTD from 10/4/16 through 11/21/16 when Dr. Singh returned Petitioner to work without restrictions for the second time.

Petitioner remained off work and under the active care of Dr. Sundar at the time of hearing. Having found that the Petitioner's current condition of ill-being and treatment are related to the 5/24/16 injury, the Arbitrator finds Petitioner is entitled to TTD benefits from 5/31/1616 through 9/26/16 and again from 10/4/16 through 2/7/17, the date of hearing.

Respondent shall pay Petitioner temporary total disability benefits of $430.58/week for 16 6/7 weeks, commencing 5/31/16 through 9/26/16, and 18 1/7 weeks, commencing 10/4/16 through 2/7/17, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $10,129.22 for temporary total disability benefits that have been paid.

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

MILLER, RONALD D
Employee/Petitioner

Case# **16WC031259**

16WC030152

CSI MANUFACTURING INC
Employer/Respondent

18IWCC0402

On 6/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% 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:

0294 KATZ & NOWINSKI PC
THOMAS E CADY
1000 36TH AVE
MOLINE, IL 61265

0766 HENNESSY & ROACH PC
GUY N MARAS
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

18IWCC0402

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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Ronald D. Miller
Employee/Petitioner

v.

CSI Manufacturing, Inc.
Employer/Respondent

Case # **16** WC **31259**

Consolidated cases: **16 WC 30152**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **2/7/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0402

FINDINGS

On the date of accident, **10/03/16**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$33,585.24**; the average weekly wage was **$645.87**.

On the date of accident, Petitioner was **58** years of age, *married* with **0** dependent children.

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

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

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

ORDER

Because Petitioner failed to establish that his current condition of ill-being is causally related to the accident of 10/03/16, benefits are denied.

Benefits are, however awarded in 16 WC 30152.

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

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

Michael K. Nowak, Arbitrator

5/31/17
Date

ICArbDec19(b)

JUN 15 2017

FINDINGS OF FACT

On 5/24/16 Petitioner was working as a Drywaller Finisher for Respondent at its company location in Cambridge, Illinois. His work included taping and mudding, sanding, applying texture sealant, climbing ladders and scaffolds, and lifting 60 to 70 pounds.

Petitioner candidly acknowledged having had prior bouts of low back which he categorized as pulled muscles. Treatment usually included medication, heat, and ice. He testified that he did not miss any work following any of the prior incidents involving his lower back.[1] On 4/25/16, he was sitting on a bucket in a van because there were no seats available. He complained of low back pain and sought medical treatment but did not miss any work.

On 5/24/16, Petitioner reported to work at around 6:30 AM and started his tasks at 7 AM. He indicated he was not experiencing any back pain when he arrived at work. He was unloading wooden doors that measured three feet by 72 inches without assistance. He testified that the doors each weighed around 50 pounds. The doors were not wrapped but did include framing. While setting the third door down, he noticed severe pain in his lower back. The Petitioner testified that he finished his shift but the pain became worse.

By the morning of Saturday, 5/28/16, the Petitioner testified that he was having trouble sleeping and standing. He sought treatment at Hammond-Henry Hospital where he was given pain killers. He was instructed to follow up with his primary care physician who referred him to an orthopedic surgeon, Dr. Berry. Dr. Berry determined that the Petitioner was not a surgical candidate but did refer him to a pain management specialist, Dr. Sundar.

Petitioner saw Dr. Sundar for the first time 8/5/16. In his office note of that date Dr. Sundar notes that Petitioner injured himself at work carrying a 75 pound door. Dr. Sundar further indicated that the work injury exacerbated Petitioner's pre-existing low grade chronic back pain significantly. Dr. Sundar recommended a series of lumbar epidural steroid injections with the first shot being performed on 8/23/16. Dr. Sundar also prescribed Gabapentin, Cyclobenzaprine, Meloxicam and Pantoprazole for Petitioner's low back pain. In a follow up visit to Dr. Sundar on 08/06/16 Petitioner indicated that the injection and medications had helped some, but he had weakness at times in the legs. Dr. Sundar planned another epidural steroid injection for 09/20/16. He also kept the Petitioner off of work.

On 9/19/16, the Petitioner saw Dr. Singh at Respondent's request pursuant to Section 12 of the Act. Dr. Singh opined that Petitioner had sustained a soft tissue muscular strain that had resolved. Dr. Singh released the Petitioner back to work full duty.

While awaiting the Dr. Singh's report Petitioner had the second epidural steroid injection with Dr. Sundar as scheduled on 9/20/16. When Dr. Singh's report became available Respondent terminated Petitioner's TTD benefits and indicated that they would pay for no further medical treatment.

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[1] The Arbitrator notes that the medical records reflect Petitioner sustained a prior injury in the year 2000 for which he did apparently miss approximately 2 weeks of work.

As a result of the termination of benefits Petitioner attempted to return to work on 9/27/16. Petitioner testified he returned to his regular job and struggled for approximately five days. Petitioner indicated that while he attempted to do all aspects of his job, he would seek help when necessary and performed his tasks much more slowly. On 10/03/16 Petitioner was on a plank attempting to "mud" a ceiling, which he described as using a 10-12 foot pole with a roller on the end to apply plaster- like material to the ceiling. Petitioner testified that while performing this task he felt extreme pain in his low back that took him down to his knees. Respondent called an ambulance and Petitioner was taken to Hammond-Henry Hospital where he was told to follow up with his primary care doctor and Dr. Sundar.

On 10/15/16 Petitioner saw Dr. Sundar's PA who noted in an office note of that day that Petitioner had had a decrease in his pain following the two epidural steroid injections, but that since returning to work the low back pain has become much more severe. The PA noted that Petitioner's low back pain was worse on the right but that it radiated to the left thigh as pain, numbness and tingling. Petitioner was continued off of work.

Petitioner saw Dr. Sundar on 11/07/16 who noted that Petitioner was having difficulty walking one block without a cane due to low back pain. Dr. Sundar noted that Petitioner's primary pain generator remains the facet arthropathy, that Petitioner was not at maximum medical improvement and the Petitioner was a candidate for a diagnostic medial branch block and consideration for a radiofrequency ablation.

The Petitioner was reexamined pursuant to Section 12 by Dr. Singh on 11/21/16. Dr. Singh again released Petitioner back to work full duty.

At the time of hearing Petitioner testified that he had the radiofrequency nerve ablation procedure the week before the hearing and had provided him 30% relief. He remained under the care of Dr. Sundar. Dr. Sundar had continued to keep Petitioner off work from 10/3/16 through the date of hearing,

CONCLUSIONS

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

Petitioner was working as a Drywall Finisher for Respondent on 5/24/16. Petitioner testified that he was unloading wooden doors that each weighed approximately 50 pounds. He testified that while setting the third door down, he noticed pain in his lower back. Respondent did not submit any evidence to the contrary.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds Petitioner has satisfied his burden in establishing that on 5/24/16, he sustained an accident arising out of and in the course of his employment.

After Respondent terminated benefits on 9/26/16 Petitioner attempted to return to work without restriction. On 10/3/16 Petitioner was on an elevated plank "mudding" a ceiling. Petitioner testified that "mudding" consisted of using a 10-12 foot pole with a roller on one end to apply texture to the ceiling. Petitioner testified that after the roller was dipped in the texture, the pole, roller and texture weighed approximately 25-30 pounds. Petitioner testified that he had had lifted the pole towards the ceiling when he felt

extreme pain in his low back that brought him to his knees. He was taken from the scene by ambulance. Respondent did not submit any evidence to the contrary.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds Petitioner has satisfied his burden in establishing that on 10/3/16, he sustained an accident arising out of and in the course of his employment.

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

The Arbitrator found Petitioner to be a credible witness. Petitioner candidly admitted he had experienced back pain intermittently in the past. He testified that he had always gone back to work following those preexisting low back episodes and was always able to perform all aspects of his physically demanding job with Respondent. Respondent offered no evidence to the contrary.

Dr. Sundar is a pain management specialist and Petitioner's primary treating physician. Dr. Sundar specifically wrote in his record of 08/05/16 "I do believe that the work-related incident to a reasonable degree of medical certainty did exacerbate his pre-existing low grade chronic back pain significantly." Dr. Sundar prescribed a series of epidural steroid injections which provided Petitioner some relief. Dr. Singh opined that Petitioner had a soft tissue strain which had resolved. He indicated Petitioner was able to return to work full duty and required no additional medical treatment. The Arbitrator finds the opinions of Dr Sundar more persuasive than those of Dr. Singh in this case.

Although Petitioner did experience an increase in his back pain on 10/3/16 the evidence in the record fails to indicate any permanent increase Petitioner's symptoms following the attempted return to work.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition of ill-being is causally related to the accident of 5/24/16. As set forth below, benefits are awarded in 16 WC 30152. The Arbitrator further finds that the accident of 10/3/16 resulted only in a transient exacerbation of Petitioner's symptoms and his current condition of ill-being is not causally related to the accident of 10/3/16. Benefits are therefore denied in 16 WC 31259.

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?

Petitioner submitted medical expenses totaling $6,769.46 (PX 6-11). Having found in favor of Petitioner with regard to the issues of accident and causal connection, and further having found the opinions of Dr. Sundar more persuasive than those of Dr. Singh, the Arbitrator finds Petitioner's submitted medical expenses are related to reasonable and necessary medical treatment as a result of Petitioner's injuries. The Arbitrator further finds Petitioner is entitled to prospective medical care.

Respondent shall pay reasonable and necessary medical services of $6,769.46, as set forth in Petitioner's exhibits 6-11, 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 further authorize and pay for prospective medical care as recommended by Dr. Sundar, as provided in Sections 8(a) and 8.2 of the Act.

Issue (L): What temporary benefits are in dispute?

The parties stipulated that Respondent paid TTD benefits from 5/31/1616 through 9/26/16 when Petitioner attempted to return to work for Respondent. The parties further stipulated that Respondent paid TTD from 10/4/16 through 11/21/16 when Dr. Singh returned Petitioner to work without restrictions for the second time.

Petitioner remained off work and under the active care of Dr. Sundar at the time of hearing. Having found that the Petitioner's current condition of ill-being and treatment are related to the 5/24/16 injury, the Arbitrator finds Petitioner is entitled to TTD benefits from 5/31/1616 through 9/26/16 and again from 10/4/16 through 2/7/17, the date of hearing.

Respondent shall pay Petitioner temporary total disability benefits of $430.58/week for 16 6/7 weeks, commencing 5/31/16 through 9/26/16, and 18 1/7 weeks, commencing 10/4/16 through 2/7/17, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $10,129.22 for temporary total disability benefits that have been paid.

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KURT MONTGOMERY,

Petitioner,

vs. NO: 94 WC 26240

CATERPILLAR LOGISTICS SERVICES, INC.,

Respondent,

18IWCC0403

DECISION AND ORDER ON §8(a) PETITION

This matter comes before the Commission on Petitioner's §8(a) Petition, requesting additional medical expenses along with penalties and attorney's fees.

Petitioner was a 27-year-old fork lift operator at the time of accident on April 8, 1994, when the forklift he was operating came in contact with another forklift. The parties entered into a lump sum settlement agreement on December 17, 1996, for all injuries and aggravations, but the right to reasonable and necessary medical care pursuant to §8(a) remained open. Petitioner's original settlement was for the neck, shoulder and right arm, with the nature of injury being upper extremity reflex sympathetic dystrophy ("RSD") with lower extremity migration. Petitioner filed his §8(a) Petitioner in 2011 alleging the wrongful denial of medical treatment. He subsequently filed his motion for penalties and fees. Petitioner went through extensive medical treatment, and on June 14, 2017, a hearing was held on the disputed §8(a) Petition, where proofs were re-opened and several witnesses were presented for both sides, and a record was made. Subsequently, oral arguments were held before Commissioner DeVriendt and Panel B on May 23, 2018.

The primary issue in this case is the appropriate treatment course based on Petitioner's complicated diagnosis and progression of his chronic regional pain syndrome. ("CRPS") Following his work-related accident, a pain specialist from Loyola saw Petitioner for 3 years and managed his CRPS with nerve blocks, physical therapy, biofeedback and counseling. Petitioner transferred to a new pain specialist, Dr. Lubenow, at Rush, where he continued therapies for CRPS including stellate ganglion blocks. In 2003, Petitioner moved to the care of Dr. Wayne Kelly and Dr. Roland in Joliet. He was recommended for a trial spinal cord stimulator and decided against

18IWCC0403

this. In 2007, Petitioner was diagnosed with cervical and lumbar radiculopathies and has undergone subsequent steroid injections for these. Petitioner has been evaluated at Arizona Pain Specialists in 2010 where a CRPS diagnosis could not be confirmed. Recommendations were made to discontinue narcotics and benzodiazepine use. Currently, the parties have appeared before the Commission regarding outstanding medical payments, prospective medical treatment and Petitioner's Motion for Penalties and Fees.

Both parties presented fact witnesses before the Commission on June 14, 2017, in support of their respective arguments. These witnesses testified to ancillary issues concerning this case. However, Respondent's independent medical examination at the Cleveland Clinic confirmed Petitioner's diagnosis as well as the need for related treatment and attendant care, so the fact witness testimony of Trisha Christensen, Michelle Zwtniowski, John Donnelly and Susan Cameron is noted and considered, but the Commission finds that none of their testimony bears any impact to the medical issues that this matter involves, and gives more weight to the medical exhibits and testimony in issuing this Order.

Findings

1) The Commission finds that Petitioner's care and treatment shall be managed by one central physician to oversee the care plan and direct all tangential modalities of treatment and necessary medications. It was the opinion of Dr. Michael Stanton-Hicks that "the patient's management over this long-time interval, it is discontinuous efforts that have been made by numerous facilities and in fact that with each new facility the overall management went back to square one instead of being a continuum of CRPS pain management." The Commission opines that it is in the best interest of the Petitioner to have continuity of care through one central treater. The Commission orders that this treater must oversee *ALL* treatment and attendant care related to the April 8, 1994, injury.

a. The Commission finds this treater cannot be Petitioner's current physician, Dr. Wayne Kelly. The Commission has weighed the medical records and testimony of Dr. Kelly against the medical records of Petitioner's other providers, as well as the report and recommendation of the physicians from the Cleveland Clinic. The Commission finds that based on the evidence, Petitioner needs a continuum of care of a central provider, and Dr. Kelly has previously discontinued treatment including sympathetic block, psychological counseling, physical therapy, and stopping writing prescriptions or monitoring the acupuncture, massage therapy or biofeedback. Dr. Kelly has additionally increased the amount of opioids prescribed, rather than taper down these medications. The Commission finds that Petitioner's treatment will be better served by a central treatment physician to oversee all modalities of treatment and taper down opioid medications.

b. The Commission is of the opinion that the best treatment option has been offered by Dr. Stanton-Hicks and the Cleveland Clinic through its report dated July 13, 2016, and this would be the best option for treatment management. However, the Commission orders that the central treater must be either from the Cleveland Clinic; or from an accredited, university based center in the Chicago-area such as Northwestern Memorial Hospital, Rush, University of Chicago, or Loyola; or from an accredited and university-based center in Arizona where Petitioner currently resides.

18IWCC0403

c. The agreed upon provider shall provide Respondent with twice yearly status reports.
d. Any evaluation, treatment, treatment modality or medication not provided by and/or dictated by the central treater shall be the sole financial responsibility of the Petitioner.

2) The Commission finds that Petitioner has failed to prove that his radiculopathy is causally related to the April 8, 1994, accident and therefore treatment and attendant care for the radiculopathy is denied.

3) The Commission finds that Petitioner's gastrointestinal issues are causally related to the April 8, 1994, accident and therefore Respondent is liable for reasonable and necessary medical treatment associated with Petitioner's gastrointestinal issues to be managed at the direction of the central treater as outlined above.

4) The Commission finds that the life care plan proposed by Mila Carlson, a nurse and PhD, is pre-mature and should not be considered until a medical care plan is implemented pursuant to this Order.

5) All bills for necessary and related treatment, attendant care and travel are to be directed for approval and payment to Respondent. Petitioner's request for a pre-pay fund is denied.

6) Respondent shall replace Petitioner's Jobst stockings and gloves on a yearly basis.

7) Respondent shall pay all outstanding reasonable and related medical bills.

8) Petitioner's Motion for Penalties and Fees is denied.

9) Petitioner did not treat outside the chain of physicians.

IT IS THEREFORE ORDERED BY THE COMMISSION that the parties submit to the Commission the name of an agreed upon central treating physician to manage Petitioner's care and treatment and oversee and refer necessary modalities of treatment.

IT IS FURTHER ORDERED BY THE COMMISSION that treatment and attendant care for Petitioner's radiculopathy is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for treatment and attendant care for necessary and related gastrointestinal issues.

IT IS FURTHER ORDERED BY THE COMMISSION that all bills for necessary and related treatment, attendant care and travel are to be directed for approval and payment to Respondent.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable, necessary, and related medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties and Fees is denied.

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

18IWCC0403

file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 26 2018

Charles J. DeVriendt

Joshua D. Luskin

Kevin W. Lamborn

CJD/dmm
O:052318
049

STATE OF ILLINOIS)

COUNTY OF VERMILION)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James C. Williams,
Petitioner,

vs.

NO: 11 WC 29736

Interstate Cleaning Corp.,
Respondent.

18IWCC0404

DECISION AND OPINION ON REMAND

This case now comes before the Commission on remand from the Circuit Court of Vermilion County.

Briefly, this claim originally proceeded to hearing pursuant to Sections 19(b) and 8(a) before Arbitrator Nancy Lindsay on July 11, 2013. On September 4, 2013, Arbitrator Lindsay found in favor of the claimant, awarding temporary total disability benefits (TTD), liability for recommended future medical treatment, and penalties and fees regarding a TTD cutoff in 2013, but denied penalties and fees regarding a TTD cutoff in 2011. Both parties filed petitions for review of that decision to the Commission, which issued a decision on July 25, 2014 (see 14 IWCC 0615) in which the Commission supplemented the Arbitrator's reasoning and findings but otherwise affirmed and adopted her award, and then remanded the case to arbitration pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

On December 10, 2015, this matter proceeded to hearing on all issues before Arbitrator William Gallagher. On February 2, 2016, Arbitrator Gallagher issued a decision in which he found that the claimant had achieved maximum medical improvement on November 14, 2013, and that he had established permanent total disability pursuant to the "odd-lot" theory. The respondent petitioned the case for review by the Commission, which affirmed and adopted his decision.

Both parties appealed the decision to the Circuit Court. The claimant appealed the issue of the unawarded penalties from 2011 which had been addressed by Arbitrator Lindsay and the prior Commission panel in 2013 and 2014, respectively, and the respondent-employer appealed the issue of the nature and extent of the injury and the sufficiency of the evidence adduced to prove the "odd-lot" permanent and total disability. The Circuit Court affirmed the Commission as to the nature and extent of the injury, but remanded the case to the Commission to address the penalties issue, noting the Commission should specifically address the issue of "the [claimant's] termination being an appropriate bar to the penalties petition based upon the record and law which applies."

As a preliminary matter, the Commission notes three areas of concern, which it will delineate and address below. Notwithstanding these concerns, the Commission notes the holding in *Terry Noonan v Illinois Workers' Compensation Commission*, 2016 IL App (1st) 152300WC. "Where a cause is remanded by a court of review to a lower court with directions to enter a certain order or decree, the latter court has no discretion but to enter the decree as directed." *Id.*, internally citing *Northwestern University, v. Industrial Comm'n*, 409 Ill. 216, 219, 99 N.E.2d 18, 20 (1951) and *People ex rel. Campo v. Matchett*, 394 Ill. 464, 469, 68 N.E.2d 747, 749 (1946). While the Circuit Court did not expressly dictate a certain order or decree, the Commission cannot disregard the Court's order despite the below-described issues.

The Commission's first concern is that jurisdiction regarding the penalties attached to the 2011 TTD period would properly have attached to the first trial and were addressed by the Arbitrator and then by the Commission panel which sat on review at that time; Arbitrator Gallagher did not address them in his decision, and they were not addressed by the parties in the Commission's review of that decision. Moreover, the prior Commission decision is long since final and the established law of the case to that point, and the Commission is unclear as to how that issue would remain justiciable at this juncture.

Second, in rendering its determination as to the remand, the Circuit Court's legal and factual analysis utilized the "clearly erroneous" standard as articulated in, *inter alia*, *Messer and Stilp, Ltd. v. The Department of Employment Security et al*, 392 Ill.App.3d 849, 910 N.E.2d 1223, 2009 Ill.App.LEXIS 517 (1st Dist. 2009). Subsequent to the Circuit Court's ruling, however, the Appellate Court handed down its decision in *Rechenberg v. Illinois Workers' Compensation Commission*, 2018 IL App (2d) 170263WC (2nd Dist. 2018), in which the Appellate Court clarified that the "clearly erroneous" standard is inapplicable to Workers' Compensation appeals. The Appellate Court further wrote:

> In *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶ 18, 956 N.E.2d 543, we expressly noted that the "supreme court has never applied [the clearly erroneous standard] to an appeal involving a decision of the Workers' Compensation Commission." That statement remains true today. [...] Further, we emphasize that, unless and until the supreme court directs otherwise, we continue to apply only the manifest-weight-of-the-evidence and *de novo* standards of review when reviewing decisions of the Commission.

Id. at ¶ 44-45. Again, as noted, the Commission does not believe it has the discretion to disregard the Court's directive, but the basis for the analysis leading to that directive is not extant or applicable. Whether that directive thus remains appropriate is an issue which is beyond the Commission's prerogative to assess.

Thirdly, in the initial hearing, Arbitrator Lindsay relied on a Commission decision, *Matuszczak v. Wal-Mart*, 12 IWCC 1079, and the Commission panel in 14 IWCC 0615 favorably noted the reasonableness of that reliance. To briefly recap that case, a Wal-Mart employee on light duty work restrictions was terminated after the employer discovered that he had stolen cigarettes from the store inventory. The Commission had denied the petitioner's TTD request, finding the claimant's theft (and termination for it) to be sufficient to demonstrate a rejection of light duty work. The parallels of the facts in *Matuszczak* to the case at bar were properly noted by Arbitrator Lindsay in rendering her decision, and by the prior Commission panel in upholding it.

18IWCC0404

However, the *Matuszczak* case had been appealed, and following the earlier Commission panel's order, the Appellate Court handed down *Matuszczak v. Industrial Commission*, 2014 IL App (2d) 130532WC (2nd Dist. 2014). The Appellate Court's analysis was that the justifiability of the petitioner's discharge from employment was legally distinguishable from the issue of disability in the workers' compensation case, and reinstituted the disputed TTD benefits which had been denied by the Commission.

Given the developments in the controlling case law, the legal analyses of, one, the impact of this claimant's termination on his eligibility for TTD benefits and, two, the potential for penalties under those circumstances, are clearly different now from what they would have been at the time. This panel finds that the respondent's actions in reliance on the persuasive law as it was understood at the time were understandable, and we find that Arbitrator Lindsay's conclusions as to the denial of penalties regarding that issue were reasonable and appropriate. Had the denial of benefits occurred after the Appellate Court's decision, a different conclusion would likely be appropriate, and would almost certainly have been reached by the Arbitrator under those circumstances. However, that is a hypothetical which is beyond the scope of the facts of this case or the Commission's present analysis.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Commission affirming the Decision of the Arbitrator filed February 2, 2016 is hereby supplemented as stated above, and that such Decision is otherwise affirmed and adopted. A copy of that decision is hereby attached for reference.

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 26 2018

Joshua D. Luskin

Charles J. DeVriendt

jdl/ac
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18IWCC0404

SPECIAL CONCURRING OPINION

I join the majority's decision and analysis. I write separately to expand on the legal analysis.

Procedural History

Petitioner sustained injury to his lower back on December 27, 2009. The matter proceeded to an immediate hearing pursuant to Section 19(b) of the Act on June 11, 2013 before Arbitrator Lindsay. On September 9, 2013, Arbitrator Lindsay entered her decision on the disputed issues. Of note, Arbitrator Lindsay denied penalties for the period of May 11, 2011 through December 24, 2011. Arbitrator Lindsay found Respondent possessed a good faith basis for its denial based upon the law at that time.

Petitioner filed a timely petition for review to the Commission on the sole issue of penalties specifically the arbitrator's failure to award the same. On July 25, 2014, the Commission issued a decision affirming the arbitrator's decision as to the denial of penalties based upon a theory of *laches*. Neither party appealed the Commission's decision. Therefore, that decision became final as to all issues decided therein. The matter was remanded to the arbitrator pursuant to *Thomas v. Industrial Commission*, 377 Ill. 587, 37 N.E.2d 350 (1941).

On December 10, 2015, the matter proceeded to hearing for a second time on the issues of causation, medical services, temporary total disability benefits, and the nature and extent of the injury. Penalties and fees were not issues in dispute. On February 2, 2016, Arbitrator Gallagher entered his decision awarding certain medical bills and temporary total disability benefits as well as awarding Petitioner permanent total disability benefits based upon an odd-lot theory of recovery. Respondent filed a timely petition for review to the Commission on the issues of temporary total disability benefits, medical expenses, and permanent total disability benefits. On December 6, 2016, the Commission entered its decision affirming and adopting the decision of the arbitrator.

Respondent filed a timely review to the Circuit Court of Vermillion County. Petitioner did not file a separate review but argued Petitioner was entitled to the penalties denied in the initial 19(b) hearing. On August 4, 2017, the circuit court entered its decision affirming the Commission's decision regarding the award of permanent total disability benefits. Further, the court remanded the matter to the Commission for a further consideration of the award of penalties to be assessed regarding Respondent's "good faith basis" for its denial and not a theory of *laches*. Pursuant to this order, this matter presently pends before the Commission.

Conclusions of Law

This Commissioner believes the circuit court's order requiring the Commission to review the issue of penalties is compelling the Commission to enter a decision which is void. Therefore, the Commission at the direction of the circuit court must enter a decision without legal effect.

The Commission is an administrative body and can only act in conformity with the Act. Any action taken outside the parameters of the Act is void. *Siddens v. Industrial Commission*, 304 Ill. App. 3d 506, 711 N.E.2d 18 (1999). Further,

> The term "jurisdiction," while not strictly applicable to an administrative agency, may be employed to designate the authority of the agency to act. In administrative law, the term "jurisdiction" has three aspects: (1) personal jurisdiction, (2) subject-matter jurisdiction, and (3) the agency's scope of statutory authority. [citation omitted]. A judgment or order is void where it is entered by a court or agency which lacks personal jurisdiction, subject-matter jurisdiction, or the inherent power to enter the particular judgment or order, or where the order is procured by fraud. *Id.* at 510-511.

This Commissioner believes the Commission lacks subject matter jurisdiction as it relates to the issue of penalties.

On September 9, 2013 Arbitrator Lindsay entered her decision denying penalties. On July 25, 2014, the Commission entered its decision affirming and adopting the arbitrator's decision. Neither party appealed the Commission's decision, therefore the Commission's decision became final on August 14, 2014. As the court noted in *Elmhurst-Chicago Stone Co. v. Industrial Commission*, 269 Ill. App. 3d 902, 905 (1995), "each section 19(b) decision was and is a separate and appealable order." "Furthermore, the decision of the Commission shall be 'conclusive unless reviewed' as provided in the Act. (Ill. Rev. Stat. 1985, ch. 48, par. 19(f).) The decision of the Commission, therefore, could properly be appealed, notwithstanding the need to later remand to the arbitrator for a finding on this issue of permanency." *F & E Erection Co. v. Industrial Commission*, 162 Ill. App. 3d 156, 168, 514 N.E.2d 1147 (1987).

The Petitioner could have challenged the validity of the Commission's decision by filing an appeal in 2014. He chose not to do so. The circuit court lacks jurisdiction to review the Commission's decision entered on July 25, 2014. As such, so does this Commission.

"Its frustration notwithstanding, the Commission could not simply ignore the circuit court's order. No matter how defective the circuit court's reasoning may have been, the Commission was charged with following the court's order..." *Noonan v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 152300WC, ¶11.

To avoid the assessment of penalties Respondent "bears the burden of justifying the delay if the employee challenges it, and the employer is held to a standard of objective reasonableness in order to avoid the severe sanctions of *sections 19(k)* and *(l)* and the attorneys fees and costs provisions of *section 16 of the Act* (see *820 ILCS 305/19(k), (l), 16* (West 1998))." *R. D. Masonry v. Industrial Commission*, 215 Ill. 2d 397, 408-409, 830 N.E.2d 584 (2005). "Thus it is not good enough to merely assert honest belief that the employee's claim is invalid or that his award is not supported by the evidence; the employer's belief is 'honest' only if the facts which a reasonable

person in the employer's position would have justify it." *Board of Education v. Industrial Commission*, 93 Ill. 2d 1, 9-10, 442 N. E.2d 861 (1982).

In the present matter, Respondent possessed a reasonable belief that temporary total disability benefits were not owed. As the arbitrator noted, Petitioner was terminated due to a cause unrelated to his injury. The prevailing law at that time provided Respondent a good faith basis to justify its refusal to pay temporary total disability benefits. The fact the law was subsequently modified by the Appellate Court has no bearing on Respondent's reasonable belief in 2011.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRIDGET DOMINICK,

Petitioner,

vs.

NO: 16 WC 11653

GRAND PRAIRIE TRANSIT,

18IWCC0405

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 expenses, temporary total disability, permanent partial disability, and penalties, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission reverses the Arbitrator regarding accident. There is no question that Petitioner was on Respondent's premises when she fell. The evidence is also clear that Petitioner sustained an injury to her left knee and leg, as a result of her fall. The Arbitrator denied accident on the basis that the alleged mechanism of injury reported was not consistent and it can be inferred that the Arbitrator believed this to be an idiopathic fall, rather than as a result of the condition of Respondent's premises. However, the Commission disagrees and finds that the Petitioner has met her burden of proof regarding mechanism of injury and accident. Accidental injuries sustained on an employer's premises within a reasonable time before and after work are generally deemed to be in the course of the employment. However, the fact that an injury is in the course of the employment is not sufficient to impose liability; to be compensable, the injury must also "arise out of" the 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. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 203 (2003), Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill.2d 52, 62 (1989).

18IWCC0405

The disputed issue here concerns the "arising out of" element of a workers' compensation claim. There are three types of risks to which an employee might be exposed: (1) risks distinctly associated with the employment; (2) risks which are personal to the employee, such as idiopathic falls; and (3) neutral risks which have no particular employment or personal characteristic. Potenzo v. Illinois Workers' Compensation Comm'n, 378 Ill. App.3d 113, 116 (2007). Risks are distinctly associated with employment when, at the time of injury, "the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties." Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill.2d 52, 58 (1989). "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." Id. 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 her 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. Id.

In the instant case, Petitioner testified that when she returned to the bus lot to park the short bus which she was driving in its assigned spot, the bus next to her was parked really close. (T. 22) The short bus was different than a regular bus as there was a driver's side door which was like a van. The other buses did not have a driver's side door. (T. 14-15) The pictures entered into evidence (Px10) depict a gravel lot with varying sized potholes throughout. Respondent stipulated this was an accurate depiction of the parking lot. Petitioner credibly testified that because of where her bus was parked in relation to the bus next to it, she was unable to visualize where she was stepping down. (T. 25)

The Arbitrator ruled that because of the written records of Petitioner's account of accident to the ambulance personnel and the emergency department personnel don't reference falling due to a pothole, that the later consistent version of mechanism of injury to all other providers was not credible. The Commission finds that the initial lack of reference to a pothole does not, in this case, outweigh the consistent history and description of the parking lot. The Commission therefore reverses the Arbitrator regarding accident.

Petitioner claims inability to work following her accident. Her treating physician placed her at maximum medical improvement as of January 13, 2017. The Commission finds that Petitioner is entitled to TTD from December 18, 2015 through January 13, 2017, based on the injuries incurred.

The Commission additionally finds that Petitioner proved that her knee injury, but not the chronic regional pain syndrome ("CRPS"), is causally related to the December 17, 2015, accident. Petitioner credibly testified that she had no prior injuries to her left leg, that she fell as she was exiting her bus, and that she sustained serious and on-going injuries as a result thereof. Petitioner sustained a twisting injury to her knee. There was no evidence of acute fracture or dislocation. She had a questionable meniscal tear and underwent substantial PT, manipulation under anesthesia and steroid injection. Given the impaired motion, ongoing use of a crutch, and ongoing problems, the Commission awards a 15% loss of use of the left leg.

Because Petitioner's injury occurred post September 1, 2011, the Commission addresses the §8.1b factors as follows: (i) no impairment rating was submitted, so the Commission gives this factor no weight; (ii) Petitioner was a bus driver at the time of injury and the Commission gives this factor some weight towards an increased permanency; (iii) Petitioner was 50 years old at the time of the injury and the Commission gives this factor some weight towards an increased permanency; (iv) Petitioner's future earning capacity may have impacted as she was unable to obtain a commercial driver's license following the accident, however, no evidence was submitted about her prior employment history nor future employability, so this factor is given little weight towards an increased permanency; (v) Petitioner met her burden of proof as to her disability to her left leg through her testimony and corroborating medical records and the Commission gives this factor some weight towards an increased permanency. Based on a weighing of the five factors as enumerated in §8.1b, the Commission finds that the Petitioner has met her burden of proof to support the award of 15% loss of use of the left leg.

The Commission also finds that Petitioner should be awarded medical bills, subject to the fee schedule, up to and including January 13, 2017, when she reached maximum medical improvement. Respondent ordered to pay the following bills subject to the fee schedule: 1) Orland Park Orthopedics in the amount of $94,933.94, for visits between December 21, 2015 and January 13, 2017; 2) South Chicago Surgical Solutions in the amount of $16,873.90 for procedures on August 9, 2016 and October 18, 2016; 3) Bob Rady, Inc., for procedures on August 9, 2016 and October 18, 2016; 4) Memorial Medical Center in the amount of $3,698.00; and Dr. Kee Shin in the amount of $140.00 for evaluation on February 8, 2016. However, the Commission does not believe that Petitioner was able to submit sufficient evidence to support a diagnosis of CRPS, and therefore denies medical expenses related to the treatment and attendant care of the CRPS.

Finally, the Commission finds that the Respondent was reasonable in denying benefits given the disputes as to accident. Therefore, no penalties or fees should be awarded.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $249.72 per week for a period of 56 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 $249.72 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 the 15% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $118,218.04 for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

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

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

18IWCC0405

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 27 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 050918
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOMINICK, BRIDGET
Employee/Petitioner

Case# **16WC011653**

GRAND PRARIE TRANSIT
Employer/Respondent

18IWCC0405

On 9/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1521 THE FITZ LAW GROUP LLC
NICHOLAS FITZ
212 W WASHINGTON ST SUITE 2004
CHICAGO, IL 60606

0208 GALLIANI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 825
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

Bridget Dominick
Employee/Petitioner

v.

Grand Prairie Transit
Employer/Respondent

Case # 16 WC 11653

Consolidated cases: ====

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Ottawa**, on **7/27/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/17/2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$12,985.44**; the average weekly wage was **$249.72**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **1** dependent children.

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

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

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

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

ORDER

THE ARBITRATOR FINDS THAT THE PETITIONER DID NOT SUSTAIN AN ACCIDENT ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT BY RESPONDENT. ALL OTHER ISSUES ARE RENDERED MOOT. 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.

Carolyn M. Doherty

Signature of Arbitrator

8/29/17
Date

ICArbDec p 2

SEP - 5 2017

FINDINGS OF FACT

At trial, Petitioner testified that she was employed by the respondent as a bus driver for seven months. Petitioner testified that she drove a shorter bus which has a driver's side door that is similar to a van or a car but higher up off the ground. The driver uses a railing and door handle to pull herself into the bus. Petitioner further testified that she drives her own car to work and parks her vehicle in an employee only parking lot. Petitioner then walks through a gate to get her bus keys from the office. Petitioner then walks through a gravel parking lot within the gated area to get her assigned bus. Petitioner testified that once on the bus she performs a pre trip inspection before starting her route. Petitioner testified that there is a monitor on the bus who rides with her during the route to monitor the children on the bus. Petitioner's monitor was Rapheala.

On the morning of December 17, 2015, she performed her route which she typically completes by 9:45 a.m. Petitioner testified that after she ran her route that day, she parked the bus in the assigned spot and performed a check of the bus to determine that no children were left on the bus and that the emergency door was closed. Petitioner left the driver's seat and walked through the bus to perform this inspection. Petitioner testified that she returned to the driver's seat, sat down and then took the key out of the ignition. Petitioner testified that Raphaela left the bus via the passenger door and Petitioner made sure the passenger door was closed. Petitioner testified that she sat again in the driver's seat and filled out the daily check list sheet which she then left in the clip board holder pouch on the bus. Petitioner was alone in the bus.

Petitioner testified that she put her purse on her left shoulder and held her keys in her right hand. Petitioner testified that she put her left hand on the door handle and put her right hand on the steering wheel. Petitioner testified that she opened the door and put her right foot on the van step. Petitioner testified that she then stepped down to the ground with her left foot. Petitioner testified that her left foot went into a pothole in the gravel parking lot and she felt a pop in her left knee. Petitioner testified that the hole was about the size of her foot and that the gravel was loose. Petitioner explained that she lost her footing when she stepped down into the hole in the gravel lot and immediately fell to the ground with pain in her left knee.

Petitioner offered several photos which the parties agree represent the parking lot at issue. Petitioner took the photos approximately 6 months after the accident. The photos depict a gravel parking lot with a number of potholes both large and small. PX 10.

Petitioner testified that she hit the ground screaming in pain. Petitioner called Raphaela on her cell phone and asked her to get help from the office. Petitioner testified that her leg began to swell while other drivers tried to help her. She testified that Tim Ronck came to the parking lot from the office and an ambulance was called. Petitioner was taken by ambulance to Silver Cross Hospital.

The ambulance records indicate, "... The patient states I stepped out of a bus and landed on my left knee. I felt a pop. I have pain and I can't feel it from the knee down. ... Crew exposed the left knee and it does not have any swelling or deformities that can be seen. She has a loss of sensation from the knee down and it hurts worse when she moves the leg from the bent position. ..." PX 1.

The ER history of present illness noted by the emergency room physician, Dr. Urumov reads, "The patient presents with knee pan and getting out of the bus after driving she felt like her leg was asleep and stepped out and her knee gave out now painful and unable to put weight on it. ... type of injury:fall." No swelling..." Under the "additional information" section the record reads, "Chief complaint from Nursing Triage Note ... had

some tingling and numbness in left leg while sitting and driving. stepped down off bus and heard popping in L knee area, fell down onto knees, denies hitting head, denies neck/back pain. c/o pain and tingling to left knee and down leg." A physical exam of the left knee revealed tenderness and limited range of motion from pain. X-rays were negative for acute fracture or dislocation. The X-ray report indicates, "Patient's left knee gave out today getting off a bus, heard a pop unable to straighten." Petitioner was given a knee immobilizer. PX 1. Petitioner was taken off work and referred to an orthopedic specialist. At trial, Petitioner testified that her ER intake was handled by a nurse with whom Petitioner had difficulty communicating although both Petitioner and the nurse spoke English. Petitioner testified that she could not understand the type of questions she was being asked, felt the questions were not appropriate and that the nurse wrote down incorrect information regarding how the accident occurred.

Petitioner was next seen by Dr. Blair Rhode, an orthopedic surgeon, on December 21, 2015. The records of Dr. Rhode reflect that she provided a history of "heard a pop down the left knee and couldn't feel from the knee down." Dr. Rhode noted "the patient presents for evaluation of a work-related left knee injury sustained on December 17, 2015. The patient was stepping down from her bus when she stepped on loose gravel and twisted. She experienced a popping sensation with sudden onset lateral knee pain which has persisted. ... she is continued to experience lateral knee pain with numbness and tingling to her fourth and fifth toe." PX 2. Dr. Rhode examined the left knee and noted no evidence of medial joint line tenderness, lateral joint line tenderness, a positive McMurray along the lateral joint line and a negative McMurray along the medial joint line. Dr. Rhode diagnosed a lateral meniscal tear and ordered an MRI of the left knee. At the December 17, 2015 visit Dr. Rhode further noted, "the patient sustained a work -related injury on December 17, 2015 she stepped off the bus onto loose gravel and pivoted on her knee. She experienced sudden onset lateral knee pain which has persisted. On exam, the patient is exquisitely tender along the lateral joint line with a positive lateral McMurray. Her x-rays do not demonstrate evidence of degenerative changes...."

Petitioner agreed that on December 29, 2015, she spoke to Anne Johnson, a claims rep for Respondent, regarding the accident. The printed claim notes from Anne Johnson of Gallagher Bassett Services reflect that a statement was taken from the petitioner on that date. RX 1. The notes indicate that the statement from Petitioner was not recorded because Petitioner refused to give a recorded statement. The notes reflect that Petitioner advised that she was "stepping down out of the bus and felt her left knee pop a couple times. There was nothing on the bus step and nothing wrong with the parking lot. She advised that there were pot holes throughout the parking lot but did not specifically indicate that there was a pot hole where she stepped." RX 1.

The MRI of December 30, 2015 showed intact ligaments, frayed free edge posterior horn lateral meniscus near the root junction, noncommunicating posterior lateral intrameniscal signal not confirmatory for tear, localized chondromalacia medial patellar facet and adjacent mildly thickened superomedial plica." PX 2.

On January 4, 2016, Dr. Rhode performed an injection to the knee "for both diagnostic/therapeutic purposes." On January 11, 2016, Dr. Rhode noted that Petitioner had no relief from the injection and ordered physical therapy. The initial PT history taken on 1/14/16 indicates ".. the pain initially started on 12/17/15. The apparent precipitating event was a fall." PX 2. On 1/25/17, Dr. Rhode noted Petitioner's continued pain complaints in the anterior knee with continued catching. He noted that her exam findings "appear patellofemoral." He continued PD and considered a repeat injection. The knee swelling and pain continued and on 2/26/16, Dr. Rhode administered another injection under the diagnosis of lateral meniscal tear.

On 3/11/16, PA Mark Bordick recommended proceeding with manipulation under anesthesia and arthroscopy of the left knee due to failure of conservative measures. In April 2016, Dr. Rhode noted that Petitioner was

scheduled for an IME. He continued her medications and off work status while awaiting approval to proceed with care.

Petitioner underwent an examination at the request of her employer by Dr. Lawrence Lieber on April 21, 2016. PX 7, RX 4. Petitioner reported "... an alleged work event on December 17, 2015, working for Grand Prairie Transit as a bus driver. Petitioner states while getting off the bus she stepped into a large hole with unstable gravel causing a twisting injury to her left lower extremity knee area. She states it was associated with a pop and pain." RX 4. She presented using crutches. The physical examination showed almost complete stiffness of the left knee with the inability to move it both passively and actively. He further noted tenderness to light touch. It was erythematous and cool to the touch. His review of the MRI showed no meniscal tear only chondromalacia of the patellofemoral joint. He diagnosed status post-contusion/strain to the left knee and associated possible reflex sympathetic dystrophy. He recommended a workup for regional pain syndrome; if negative, then her significant signs of symptom magnification would be evident. In such case, she would be able to return to full duty without restrictions and would be at MMI. RX 4, PX 7.

On May 13, 2016, Dr. Rhode noted Dr. Lieber's RSD concern and sent Petitioner for evaluation by Dr. Lubenow. PX 2. On June 1, 2016, she was examined by Dr. Konowitz under Section 12. He recommended that Petitioner see Dr. Rechitsky, a neurologist. PX 8. In the interim, sympathetic nerve blocks were recommended and performed on 8/9/16 by Dr. Rhode under a diagnosis of CRPS. PX 3. Petitioner's symptoms continued.

Petitioner saw Dr. Rechitsky on 8/31/16 and reported stepping off the bus into a pothole badly twisting the left leg and falling down. He attempted to perform an EMG but could not complete the testing because it was too painful. According to the report of Dr. Rechitsky the EMG was terminated because, "she developed sobbing, screaming behavior." He indicated that it was unlikely that the left common peroneal neuropathy is the cause of her symptoms. Complex regional pain syndrome was likely based on patient history. He recommended further orthopedic testing consisting of MRI, CT Scan, arthrogram. He further noted, "given obvious behavioral manifestations of her condition, pain psychology or psychiatry involvement in her care (evaluation for underlying depression etc) could be considered. PX 9.

Petitioner was eventually evaluated by Dr. Trudeau on 9/26/16 who successfully performed and EMG and diagnosed Petitioner with peroneal neuropathy at/distal to the left fibular head with a multitude of contributing factors in the syptomotology. PX 5. He deferred care to Dr. Rhode.

On October 18, 2016, Dr. Rhode performed a manipulation under anesthesia on her left knee under a diagnosis of left knee arthrofibrosis. Petitioner's preoperative range of motion was found to -10-110 degrees. Multiple soft tissue clicks were appreciated during manipulation. Petitioner's post operative range of motion was 0-130 degrees. PX 3. She was sent for additional physical therapy.

On January 13, 2017, Dr. Rhode placed her at maximum medical improvement and placed her on permanent modified sedentary duty with a 10-lb. lifting restriction. The physical examination showed range of motion of the knee at 0/130 degrees; full active and passive flexion and extension; and medial and lateral joint line tenderness. The diagnosis was lateral meniscal tear and patellar chondromalacia. Petitioner was to follow up on an as needed basis with instructions to use a crutch as needed and the potential for future oral medication. The final examination was on April 12, 2017 and the findings and diagnosis remained the same. Petitioner had continued knee pain with the inability to walk more than 5 blocks and difficulty with stairs. The sedentary permanency status was continued. PX 2.

Petitioner was examined by Dr. Konowitz, who is board-certified in pain management and anesthesiology, on June 22, 2017. PX 8, RX 5. He noted that Petitioner reported a history of driving a bus. She reported that it had rained the night before her fall and there were pot holes in the gravel parking lot. Petitioner described slipping in the pothole and landing on her buttocks with an associated left knee popping sensation and swelling over the knee and distal thigh. RX 4. The neurological examination showed no focal deficits, cranial nerves grossly intact with normal reflexes, coordination, muscle strength and tone. Examination of the left knee revealed tenderness and swelling in the patellar region; no erythema; and range of motion of -10 – 110. He opined that although the petitioner may have showed signs of complex regional pain syndrome at the June 1, 2016 evaluation, she did not meet the clinical diagnostic criteria for CRPS at the examination of June 22, 2017. He diagnosed left knee pain and common fibular nerve neuralgia. He noted that all treatment to date had been reasonable and necessary. He concurred with the need for sedentary duty and that the petitioner had reached maximum medical improvement. He noted that if she continued to improve with an exercise program her ability to work would also improve. He noted no signs of symptom magnification. (Resp. Ex. 5)

Petitioner testified that after her January 2017 sedentary work restrictions and release from Dr. Rhode, she returned to Respondent with her restrictions. Petitioner testified that she was told Respondent could not accommodate her restrictions.

Petitioner testified that she currently performs a home exercise program consisting of a treadmill, pool therapy and peddling a bike. She notices numbness and tingling in the left side of her leg. She has difficulty placing her weight on her left leg. Petitioner testified that she is unable to walk normally and walks on her toes. She is unable to fully straighten her left leg, which is smaller than the right leg. She has less hair growth on the left leg along with red spots. Petitioner confirmed that she never attempted to undergo an Illinois Department of Transportation physical to determine if she could return back to work as a bus driver. Petitioner testified that she is no longer able to perform the duties of a bus driver. She continues to driver her personal automobile at the present time.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

With respect to issue (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?" the Arbitrator concludes the following:

For an injury to be compensable under the Illinois Worker's Compensation Act, it must arise out of the employment, from a risk connected with or incidental to the employment creating a causal connection between employment and the accidental injury. In this matter, Petitioner clearly testified that she was required to step off the bus onto an employee only gravel parking lot which contained pot holes, and thus asserts that such risk was associated with her employment. The Arbitrator specifically notes Petitioner's adamant testimony that she stepped off the bus and into a pot hole in the gravel parking lot which caused her knee to twist resulting in her injury. Based on the record at trial, it is clear that Petitioner suffered an injury to her left knee while at work and in the course of her employment as a bus driver on 12/17/15. However, based upon a preponderance of the credible evidence introduced at trial the Arbitrator finds that Petitioner's injury to her left knee did not arise out of her employment with Respondent so as to make her injury compensable under the Act.

Petitioner's assertion that her injury arose out of her employment due to the increased risk posed by the subject pot hole in the parking lot is not lost on the Arbitrator. However, the Arbitrator is not persuaded to find that the subject pot hole/defect was actually involved in Petitioner's fall such that Petitioner faced an increased risk of injury getting out of the bus. In so stating, the Arbitrator again notes Petitioner's adamant and specific testimony at trial that her left foot stepped into a pot hole in the parking lot causing her injury. However, Petitioner's testimony regarding a defect in the parking lot, namely a pot hole, is not buttressed and is in fact contradicted by the immediate histories provided to the ambulance and emergency personnel on the date of the accident. The Arbitrator notes that the ambulance report indicates "... The patient states I stepped out of a bus and landed on my left knee. I felt a pop. I have pain and I can't feel it from the knee down. ... Crew exposed the left knee and it does not have any swelling or deformities that can be seen. She has a loss of sensation from the knee down and it hurts worse when she moves the leg from the bent position. ..." PX 1. The ER history of present illness noted by the emergency room physician, Dr. Urumov reads, "The patient presents with knee pain and getting out of the bus after driving she felt like her leg was asleep and stepped out and her knee gave out now painful and unable to put weight on it. ... type of injury:fall." No swelling..." Under the "additional information" section the record reads, "Chief complaint from Nursing Triage Note ... had some tingling and numbness in left leg while sitting and driving, stepped down off bus and heard popping in L knee area, fell down onto knees, denies hitting head, denies neck/back pain, c/o pain and tingling to left knee and down leg." The X-ray report indicates, "Patient's left knee gave out today getting off a bus, heard a pop unable to straighten." PX 1.

Four days later, Petitioner was seen by Dr. Rhode on December 21, 2015. The records of Dr. Rhode reflect that she provided a history of "heard a pop down the left knee and couldn't feel from the knee down." Dr. Rhode further noted "the patient presents for evaluation of a work-related left knee injury sustained on December 17, 2015. The patient was stepping down from her bus when she stepped on loose gravel and twisted. At the December 17, 2015 visit Dr. Rhode further noted, "the patient sustained a work -related injury on December 17, 2015 she stepped off the bus onto loose gravel and pivoted on her knee. The Arbitrator notes that as of December 21, 2015, the history has changed and now mentions loose gravel with twisting. In addition, Dr. Rhode's records do not document a pot hole.

On December 29, 2015, Anne Johnson noted that Petitioner advised that she was "stepping down out of the bus and felt her left knee pop a couple times. There was nothing on the bus step and nothing wrong with the parking lot. She advised that there were pot holes throughout the parking lot but did not specifically indicate that there was a pot hole where she stepped." RX 1. Petitioner's first mention of the involvement of a pot hole was not until her April 21, 2016 Section 12 exam with Dr. Lieber who noted Petitioner reported "... an alleged work event on December 17, 2015, working for Grand Prairie Transit as a bus driver. Petitioner states while getting off the bus she stepped into a large hole with unstable gravel causing a twisting injury to her left lower extremity knee area.

Given the discrepancies between the recorded histories in the medical records and Petitioner's trial testimony, the Arbitrator is not persuaded to find the existence of a defect in the parking lot involved with Petitioner's fall such that Petitioner's risk of injury was increased and thus arose out of her employment. Based upon the totality of the evidence at trial, the Arbitrator finds that Petitioner did not sustain an accident arising out of her employment with Respondent on 12/17/15. Accordingly, the Arbitrator makes no award of benefits under the Act and the remaining issues are rendered moot.

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

Miguel Guadalupe,

Petitioner,

vs.

NO: 14 WC 10861

Dept. of Lottery/State of Illinois,

18IWCC0406

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 whether an accident occurred in the course of employment, and being advised of the facts and law, affirms the Decision of the Arbitrator with changes as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms the Arbitrator's determination that Petitioner was a "traveling employee" and that he sustained accidental injuries arising out of and in the course of his employment on February 20, 2014 when he slipped and fell on black ice in the parking lot adjacent to his condominium complex. In support of this holding, the Arbitrator cited the case of *Mlynarczyk v. Illinois Workers' Compensation Commission*, 999 N.E.2d 711, 376 Ill.Dec. 536 (3rd Dist. 2013). In that case, the court held that "...a traveling employee is deemed to be in the course of his employment from the time the employee leaves home until he or she returns." *Mlynarczyk*, at 541. Here, Petitioner had left his personal residence – a condo in a building housing 60 families -- to begin his work day as a lottery sales representative – a job that required him to travel throughout the Chicagoland area to service accounts – when he was injured on the way to his state-owned vehicle while walking through a darkened parking lot that was open to both residents and the general public and which he, presumably was under no obligation to, and in fact did not, maintain. To call this area "private property", and by extension Petitioner's "home", as Respondent appears to do, defies logic, and fails to take into consideration the very real and practical concerns behind the traveling employee doctrine itself – namely, that as a traveling employee Petitioner was exposed to a risk of injury to a greater extent than a member of the general public precisely because of the travel requirements associated with his job and the frequency with which he was exposed to street hazards that we are all otherwise subjected to on a daily basis. Furthermore, there is no evidence to suggest that Petitioner was acting in an

18IWCC0406

unreasonable manner or had otherwise removed himself from the scope of his employment by reason of his conduct, or that the injury was anything but foreseeable, given the time of year and the weather conditions in play at the time of the accident. As a result, the Commission finds that Petitioner proved by a preponderance of the credible evidence that he sustained accidental injuries arising out of and in the course of his employment on February 20, 2014.

The Commission further corrects several clerical errors found at p.2 of the Arbitrator's decision. Along these lines, the Commission finds that Petitioner was temporarily totally disabled for a total of 8-4/7 weeks (not 8-3/7 weeks), for the period extending from February 21, 14, the day after the accident, through April 21, 2014, or the day before he returned to full duty work. In addition, the Commission finds that Petitioner is entitled to 25.625 weeks (not 31.25 weeks) of permanency at a rate of $580.46 per week based on the award of 12.5% loss of use of the left hand pursuant to §8(e)9, given that the maximum number of weeks for the permanent partial loss of use of the hand is 205 weeks for the period in question (.125 x 205 weeks).

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 4/20/16, with corrections, 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 27 2018
o: 5/1/18
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. In *Mlynarczyk v. Illinois Workers' Comp. Commission,* 999 N.E.2d 711, 718 the Appellate Court of Illinois, Third District held that:

> We find,... that the evidence does not support the premise that claimant's fall occurred on private property. Edward testified that he did not observe claimant fall. Claimant testified that the accident occurred adjacent to the driveway on a "public sidewalk"

> leading from the house to the driveway. Respondent presented no evidence to the contrary, and we find claimant's testimony sufficient to establish that the accident which occurred on a "public sidewalk", exposed claimant to the hazards of the street. *Mlynarczyk, 999 N.E.2d at 718*

In this matter, the Petitioner did not leave his private property and did not become exposed to the hazards of the street. Holding an employer liable for injuries which occur on an employee's private property before they have begun any work-related travel would shift the burden of risks arising from the employee's own home to the employer.

The majority incorrectly applies the doctrine of the traveling employee and the case law set forth in *Mlynarczyk*, in holding that the doctrine extends to injuries on the private property of the employee incurred prior to beginning any work-related travel.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GUADALUPE, MIGUEL
Employee/Petitioner

Case# **14WC010861**

DEPT OF LOTTERY STATE OF ILLINOIS
Employer/Respondent

18IWCC0406

On 4/20/2016, 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 0.35% 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:

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

5604 ASSISTANT ATTORNEY GENERAL
DAVID CHRISTENSEN
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

APR 20 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF DU PAGE)

☐ 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

Miguel Guadalupe
Employee/Petitioner
v.
Dept. of Lottery State of Illinois
Employer/Respondent

Case # **14 WC 010861**

An *Application for Adjustment 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 **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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other:

FINDINGS

On **February 20, 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 **$50,307.12**; the average weekly wage was **$967.44**.

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

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

ORDER

Respondent shall pay to Petitioner temporary total disability benefits of **$644.96** per week from February 21, 2014 through April 21, 2014, **8 & 3/7 weeks**, in accord with §8(b) of the Act.

Respondent shall pay to Petitioner permanent partial disability benefits due to Petitioner suffering **12.5%, 31.25 weeks,** loss of use of his left hand as a result of injuries sustained in a work-related accident on February 20, 2014, in accord with §8€ 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

April 18, 2016
Date

APR 20 2016

Miguel Guadalupe v. Dept. of Lottery State of Illinois
14 WC 010861

INTRODUCTION

This matter proceeded to hearing on July 22, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***K:*** What temporary benefits are in dispute? *TTD*; ***L:*** What is the nature and extent of the injury?

Petitioner testified at the trial.

FINDINGS OF FACT

Petitioner worked for Respondent as a Lottery sales agent. He would service accounts on the west side of Chicago, 12 to 15 per day. He drove a state-owned car assigned to him. He was authorized to keep the car at his home. During a normal workday he would travel straight from his home to his account stops.

Petitioner resided at 5900 Oakwood Dr., Unit 1B, Lisle, IL from 2005 to present. He testified that his residence is in a large complex and that his building houses approximately 60 residents. Petitioner testified that a "huge" parking area is provided for the residents. He testified that he had 3 assigned parking spots for his vehicles. These were rented from the apartment complex and were selected by Petitioner.

Petitioner further testified that he chose one specific spot for his work vehicle, about 4-6 feet from the building entrance. He testified that this was in an area designated for resident parking, which was separate from the area designated for visitor parking. He testified that the location he parked his work vehicle was not open to non-residents.

Petitioner testified that on February 20, 2014, he was leaving his apartment to begin his workday and was walking toward his state owned vehicle at about 6:30 a.m. It was dark. When he was approximately 4 to 5 feet from his vehicle, he slipped and fell on a patch of ice, landing on his left wrist. No one witnessed his fall and that he did not report his fall to the apartment complex management.

Petitioner did not testify or offer other evidence that he was carrying anything relating to his work, or whether he intended to travel to his employer's local office or one of his accounts.

Petitioner took himself to Edward Hospital Emergency Room. He was treated and discharged. Petitioner then followed up with his primary physician, Dr. Scott Anderson at Federal Health Center from March 4 through April 17, 2014. A cast was applied to his left wrist. The cast was changed on April 4 and removed on April 17.

Petitioner lost time from work from February 21 through April 21, 2014. He received only $1,100.00 in TTD for that period. He is now retired.

Petitioner testified that the only injury he suffered in this accident was a fracture to his left wrist.

Petitioner testified that he did not have any physical therapy, surgery or other like treatment. Petitioner received no additional related treatment subsequent to April 17, 2014. Petitioner testified that currently takes over-the-counter for his continuing pain & stiffness in his wrist. He continues to have some pain in his wrist when lifting or turning knobs.

Edward Hospital (PX #1)

Petitioner was seen the Emergency Department at 9:52 a.m. on February 20, 2014. He gave a history of a slip and fall onto his left wrist and hip at 6:30. He complained of left wrist and left hip pain. He denied loss of consciousness. Both wrist and hip were tender on palpation. Petitioner reported left knee pain with walking. The knee was tender. His history was significant for a prior knee replacement and diabetes.

There was mild swelling of the wrist, but full range of motion in the affected joints. X-rays were negative for fracture. Petitioner was diagnosed with a left wrist sprain and multiple contusions. He was discharged with a spica splint for his wrist.

Petitioner was seen again at Edward Hospital Emergency Department on October 25, 2014. He presented with complaints abdominal pain. There were no documented complaints of left wrist pain.

Captain James A. Lovell Federal Healthcare Center (PX #2)

Petitioner presented to the orthopedic clinic on March 4, 2014, where he was seen by Dr. Scott Anderson. Petitioner presented with left wrist pain from a fall at work 10 days before. Petitioner reported that the injury limited the use of his left hand. He reported that he had been treated in the Emergency Department immediately. No fractures were identified and Petitioner reported that he was discharged without immobilization.

On examination Dr. Anderson noted irritability on range of motion of the wrist. Strength was normal. There was mild swelling. There was a mildly positive Finkelstein maneuver. X-rays revealed significant arthrosis in the carpometacarpal (CMC) joint. Dr. Anderson was concerned about a possible scaphoid fracture. He ordered a pica short arm cast and an MRI.

Petitioner returned on March 9, 2014 for follow-up and review of the MRI. The March 6 MRI (PX #3) showed a nondisplaced fracture of the distal radius with bone contusion, degenerative triangular fibrocartilage without definitive tear, arthritic changes of the CMC, and tenosynovitis of the extensor radialis tendons. Dr. Anderson

ordered a short arm cast without spica. Dr. Anderson anticipated 5 -6 weeks of immobilization.

Petitioner was seen for follow-up on April 4, 2014. On examination his condition was essentially unchanged. On April 23, 2014 Petitioner returned to Dr. Anderson with right knee pain related to his arthritis. Examination of the right knee and the left wrist were noted as benign. Dr. Anderson decided to discontinue mobilization of the left wrist. He administered a cortisone injection to the right knee.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner proved by a preponderance of the evidence that he sustained an injury from an accident that arose out of and in the course of his employment by Respondent.

Petitioner's employment required him to travel to and from various account addresses throughout his workday. Petitioner did not work at a fixed job site. Rather, his duties required that he travel to various locations in furtherance of his job responsibilities. As such he was a traveling employee.

Even has a traveling employee Petitioner has the burden of proving that his injury arose out of and in the course of his employment at the time at issue. The test is whether at the time of the accident Petitioner was engaged in conduct in furtherance of his employment and whether such conduct might be expected by the employer. Merely commuting to and from work does not satisfy the test.

Analysis of the issue rests on whether the conduct at issue exposes the employee to hazards greater than the general public would experience. Both Petitioner and Respondent cited *Mlynarczyk v. IWCC* in support of their relative positions. Petitioner cited to the opinion of the Illinois Appellate Court, *Mlynarczyk v. IWCC*, 2013 IL App (3d) 120411 WC. On the other hand, Respondent cited to the finding of the Commission that Petitioner was not a traveling employee, a finding reversed by the Appellate Court.

The Arbitrator finds *Mlynarczyk* instructive. In *Mlynarczyk* the petitioner worked cleaning business offices, homes, and churches. The employer provided a van, operated by the petitioner's husband, to transport the petitioner to and from various workplaces. After a lunch break the petitioner slipped and fell on snowy pavement as she walked to the van to resume her workday. The arbitrator found that the petitioner was a traveling employee and that she sustained a compensable injury. The Commission reversed, finding that the petitioner was not exposed to a risk that was connected to or incidental to her employment. The Appellate Court reversed the Commission and found that the petitioner was exposed to hazards of the streets at a risk greater than the general public was exposed to. The Appellate Court particularly noted

that the analysis rested on whether the petitioner's conduct at the time of the injury was reasonable and foreseeable by the employer.

The Arbitrator finds that Petitioner here was a traveling employee who was exposed to a risk greater than what the general upon public would be exposed to in a circumstance arising out of and in the course of his employment. It was reasonable and foreseeable to Respondent that Petitioner would be exposed to greater risks of falling on snow and ice by virtue of the numerous occasions in which Petitioner would exit and enter the vehicle supplied by Respondent throughout his normal workday.

This accident did not occur during Petitioner's normal commute to or from work. The accident occurred as petitioner was leaving his home to enter a vehicle supplied by Respondent. As a travelling employee Petitioner is deemed to be in the course of his employment when he leaves home to the time when he returns home. The accident arose from his employment by Respondent because the nature of his work required frequent entrances to and exits from a vehicle provided by Respondent in furtherance of Petitioner's responsibility to make 12 to 15 business calls a day.

The Arbitrator takes note of Respondent's disingenuous argument based a decision of the Illinois Workers' Compensation Commission that was overturned by the Appellate Court.

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

The Arbitrator finds that this issue was not genuinely disputed. Respondent disputed the claim that Petitioner was injured in an accident that arose out of and in the course of his employment. The evidence was clear and undisputed that Petitioner sustained a fractured left wrist that required emergency medical care and orthopedic follow up, which included application of casts.

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

The Arbitrator also finds that the evidence clearly demonstrated that Petitioner sustained a compensable injury and was temporarily totally disabled from February 21 to April 21, 2014, or 8 & 3/7 weeks.

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

Petitioner sustained a left wrist fracture that was successfully treated with conservative care. The Arbitrator evaluated Petitioner's permanent partial disability in accord with §8.1b(b) of the Act:

(i) No AMA impairment rating was admitted in evidence. Therefore, the Arbitrator gives no weight to this factor.

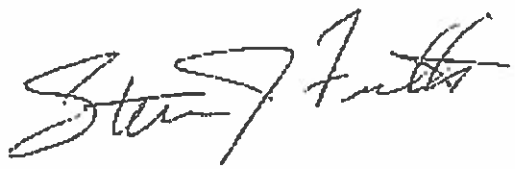
(ii) Petitioner worked as a sales representative for Respondent. There was no evidence that this occupation required heavy or sustained lifting by either hand. The Arbitrator gives this factor little weight.

(iii) Petitioner was 63 years old at the time of his accident. He had a statistical life expectancy of 21 years, and a statistical worklife expectancy of 5 years. The Arbitrator notes that petitioner was retired at the time of trial. The Arbitrator also notes that individuals of Petitioner's age may experience ongoing complaints at greater frequency than younger persons. The Arbitrator gives this factor greater weight.

(iv) Petitioner returned to his regular job duties after release by his physicians. There was no evidence that his earning capacity was impaired other that the time off for treatment of his injuries. Also, Petitioner is now retired. Therefore, the Arbitrator gives this factor no weight.

(v) Petitioner sustained a nondisplaced fracture of his left distal radius and tenosynovitis. The fracture was treated successfully with conservative care. The evidence did not demonstrate an injury involving a disability of any significant degree.

In light of all of the foregoing factors the Arbitrator finds that Petitioner sustained permanent partial disability of 12.5%, 31.25 weeks, loss of use of his left hand due to injuries sustained in the work-related accident on February 20, 2014.



Steven J. Fruth, Arbitrator

April 18, 2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL GOYETTE,

Petitioner,

vs.

NO: 14 WC 19036

18IWCC0407

A&R LOGISTICS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, medical expenses, and penalties/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).

We affirm the Arbitrator's termination of temporary total disability benefits as of January 29, 2016, but do so based upon Petitioner's failure to prove he was restricted from returning to work. Petitioner testified he was last seen by Dr. Hinson on March 29, 2016 at which time Petitioner was released to return to work light duty. T. 44. Petitioner failed to present medical evidence from Dr. Hinson supporting this testimony. The medical records evidence Dr. Hinson last evaluated Petitioner on January 28, 2016 at which time a further prescription for physical therapy was provided. PX19. The medical records evidence Petitioner under physical therapy at Quality Performance Rehabilitation commencing on October 13, 2015. PX20. On February 5, 2016, the physical therapist noted Petitioner met all his goals and was discharged to an independent home exercise program. PX20. Despite the physical therapy records, Petitioner testified Dr. Hinson ordered further physical therapy thereafter. Given such discrepancy, the Commission declines to award temporary total disability benefits beyond January 29, 2016 as Petitioner failed to provide medical documentation. Further, at the beginning of 2016, Petitioner was offered and accepted a new job with a start date of June 1, 2016. T. 100. As such neither maintenance nor temporary total disability benefits are awarded beyond January 29, 2016.

Petitioner claimed entitlement to temporary total disability benefits from April 26, 2014 through the date of hearing of May 9, 2016. Petitioner testified he consulted with Dr. Hinson on March 29, 2016 who allegedly continued to release Petitioner to return to work with light duty restrictions. T. 44. Again, there are no medical records in evidence to support this testimony. Further Respondent's Exhibit 9 evidences Petitioner received temporary total disability benefits for the period of April 26, 2014 through October 11, 2014 with two additional payments of benefits on January 9, 2015 and October 19, 2015 all totaling $43,175.99.

Dr. Sailors, Petitioner's primary care physician authored a letter on September 12, 2014 releasing Petitioner to return to work in an office setting and/or driving a vehicle with power steering. The medical records evidence Dr. Sailors again released Petitioner to return to work on September 22, 2014 with no prolonged use of his arms above his head and shoulders. PX3. Petitioner testified in August and/or September of 2014 he requested both Dr. Sailors and Dr. Cardona to provide him a note authorizing him off-work, and both physicians refused. T. 108. The medical records evidence Nurse Koludrovich of Dr. Cardona's office noted Petitioner telephoned on August 27, 2014 requesting an off-work note, and Dr. Cardona declined to provide the same. RX13.

On November 11, 2014 Dr. Nicholas Ahn evaluated Petitioner pursuant to Section 12 of the Act at Respondent's request. On August 10, 2015, Dr. Ahn provided his testimony via evidence deposition. Dr. Ahn testified Petitioner suffered from "[c]ervical sprain and strain; a left knee strain and sprain; bilateral shoulder sprain and strain; and the left elbow sprain and strain." RX1, p. 24. Dr. Ahn testified such strains resolved approximately six weeks following the accident of April 25, 2014 and any ongoing complaints were due to Petitioner's pre-existing chronic degenerative changes. RX1, p. 27-28. Dr. Ahn provided several bases for his opinion: 1) MRIs of the cervical spine and shoulder taken following the accident evidence no acute findings (RX1, p. 19, 27); 2) the physical examination performed by Dr. Ahn was normal in findings (RX1, p. 23); and 3) the medical records in and after April 25, 2014 document exam findings consistent with Petitioner's complaints and findings prior to the accident of April 25, 2014 (RX1, p. 21, 25). Dr. Ahn testified he would defer to Petitioner's treating orthopedic physician, Dr. Schickendantz as to Petitioner's ongoing treatment, but such deference did not alter Dr. Ahn's opinions as to causation. RX1, p. 56-57.

The Petitioner argues penalties and fees should be imposed as it was unreasonable for Respondent to rely on 1) Dr. Sailors' authorization returning Petitioner to work; and 2) Dr. Ahn's opinion. "The employer, therefore, bears the burden of justifying the delay if the employee challenges it, and the employer is held to a standard of objective reasonableness in order to avoid the severe sanctions of *sections 19(k)* and *(l)* and the attorneys fees and costs provisions of *section 16 of the Act* (see *820 ILCS 305/19(k), (l), 16* (West 1998))." *R. D. Masonry v. Industrial Commission*, 215 Ill. 2d 397, 408-409, 830 N.E.2d 584 (2005). "When the employer acts in reliance upon responsible medical opinion or when there are conflicting medical opinions, penalties are not ordinarily imposed. [citation omitted]. As long as the insurer 'had a legitimate doubt, from a legal standpoint, of its liability, its conduct [refusing payment] was not unreasonable.' [citation omitted]." *Avon Products v. Industrial Commission*, 82 Ill. 2d 297, 302, 412 N.E.2d 468 (1980).

Petitioner requested both of his treating physicians to authorize him off-work. Both physicians declined to do so. Dr. Sailors released Petitioner to return to work driving a power-steering vehicle. Petitioner chose not to work instead arguing it was unreasonable for Respondent to rely on Dr. Sailors' medical opinion because Respondent was aware of the multi-faceted nature

of Petitioner's job duties. According to Petitioner, Respondent should have ignored Dr. Sailors' medical opinion as Dr. Sailors was not aware of Petitioner's job duties. Petitioner's argument is belied by his own testimony. Petitioner testified he discussed his job duties with Dr. Sailors and as part of this discussion attempted to have Dr. Sailors review a video. According to Petitioner, Dr. Sailors declined to watch the video, but Dr. Sailors provided a release to return to work. It can be inferred from Petitioner's testimony a discussion was had with Dr. Sailors regarding Petitioner's work duties, and Dr. Sailors released Petitioner to return to work. This is also consistent with Dr. Cardona's refusal to authorize Petitioner off-work despite his request for the same especially considering the fact Petitioner declined to cooperate with the recommended medical treatment (iMatch program).

Further Dr. Ahn testified Petitioner suffered from strains and sprains which resolved six weeks following Petitioner's accident. The Commission did not find Dr. Ahn's opinion persuasive as it relates to Petitioner's care for his shoulder, but Respondent's reliance on Dr. Ahn's opinion was objectively reasonable. Additionally, Respondent's conduct was not vexatious or intentional as conflicting medical opinions existed as to what treatment was reasonable, necessary, and related.

As to the issue of credit, Petitioner argues as a matter of law no evidence in the record exists to support the award of credit. The Commission disagrees. As Petitioner noted in his brief, the Illinois Rules of Evidence apply. Respondent tendered a document (RX9) which memorialized payments made to/and on behalf of Petitioner by Cottingham & Butler Claim Services, Inc. Petitioner objected based upon hearsay grounds, and the arbitrator overruled the objection. Rules of Evidence- Rule 803(6) Records of Regular Conducted Activity applies. RX9 is an exception to the hearsay rule, and no further objection was made by Petitioner. As such the record supports a finding of a credit in the amount of $43,175.99 for disability benefits.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $762.73 per week for a period of 92 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. Respondent shall receive a credit of $43,175.99 for payments already made.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner any unpaid balance of the $79,295.48 in medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

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

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

18IWCC0407

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 27 2018

SE/
O: 5/9/18
49

Joshua D. Luskin

L. Elizabeth Coppoletti

Partially Dissenting Opinion

I concur regarding all issues except the termination of temporary total disability benefits. When Dr. Hinson gave Petitioner the five-pound work restrictions on January 28, 2016, he also performed a left shoulder injection the same day and recommended continued conservative treatment, including therapy. Petitioner was not at maximum medical improvement and there is no evidence that Petitioner could return to his previous occupation. Although Petitioner testified that he had accepted a job, within his restrictions, driving people to their doctors' appointments, this job had not yet started at the time of hearing. I would award temporary total disability benefits through the hearing date on May 9, 2016.

Charles J. DeVriendt

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

GOYETTE, MICHAEL
Employee/Petitioner

Case# **14WC019036**

A & R LOGISTICS
Employer/Respondent

18IWCC0407

On 12/9/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1938 ALEKSY BELCHER
MATTHEW J BELCHER
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

0560 WIEDNER & McAULIFFE LTD
NICOLE M SCHNOOR
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

18IWCC0407

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

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

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

Case # 14 WC 19036

Michael Goyette
Employee/Petitioner

v.

A & R Logistics
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 **Christine Ory**, Arbitrator of the Commission, in the city **New Lenox**, on **May 9, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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 [X] Maintenance [X] TTD
M. [X] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [X] Other **Vocational Rehabilitation**

18IWCC0407

FINDINGS

On the date of accident **April 25, 2014** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$59,493.20;** the average weekly wage was **$1,144.10**

On the date of accident, Petitioner was **43** 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 **$38,027.54** for **0** for TPD, **$0** for maintenance, and **$5,158.45** for other benefits, for a total credit of **$43,185.99.**

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, that were not already paid of the **$79,295.48 bills claimed**, in accordance with the fee schedule and in accordance with §8(a) and §8.2 of the Act.

Respondent shall pay for all reasonable and necessary treatment of petitioner's left shoulder as prescribed by Dr. Hinson after March 29, 2016; sleep study as prescribed by Dr. Conidi; and psychiatric medication evaluation of petitioner's head symptoms per Dr. Askenanzi.

Temporary Total Disability and Maintenance

Respondent shall pay Petitioner temporary total disability benefits at the rate of **$762.73** per week for **92 weeks**, commencing **April 26, 2014 through January 29, 2016**. The claim for maintenance is denied.

Penalties and Attorneys' Fees

The claim 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.

Christine Mroz

December 7, 2016

Signature of Arbitrator

Date

DEC 9 - 2016

18IWCC0407

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Goyette	)	
Petitioner,	)	
vs.	)	**No. 14 WC 19036**
A & R Logistics	)	
Respondent.	)	
	)	

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in New Lenox under the provisions of §19b/§8a on May 9, 2016. The parties agree that on April 25, 2014, the Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and their relationship was one of employee and employer. They agree Petitioner sustained accidental injuries in an accident that arose out of and in the course of his employment with Respondent and that Respondent was given notice of the accident within the time limits stated in the Act. They further agree Petitioner's wage for the year pre-dating the accident was $59,493.20 and Petitioner's average weekly wage as calculated pursuant to §10 was $1,144.10.

At issue in this hearing is as follows:

1. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
2. Whether respondent is liable for the unpaid medical bills
3. Whether petitioner is entitled to payment for prospective medical treatment.
4. Whether petitioner is due TTD and maintenance benefits.
5. Whether penalties and fees should be imposed upon respondent.
6. Whether petitioner is entitled to vocational rehabilitation.

STATEMENT OF FACTS

Petitioner testified in his own behalf. He presently lives in Florida, where he has lived for eight months. Petitioner moved from Ohio to Florida as his wife had a better job opportunity. Petitioner is not presently working, but does have job lined up to drive people to their doctor's appointment.

Petitioner has over 20 years' truck driving experience. Petitioner was hired by respondent as a truck driver in July, 2012. Petitioner underwent a functional test to drive in Ohio. His orientation and hiring took place in Illinois. Prior to his employment with respondent petitioner was a truck driver. Before that, he worked for a private contractor in Iraq. He passed a physical before and after leaving Iraq.

On April 25, 2014, when petitioner was driving in Pennsylvania, he was startled and rolled respondent's tractor trailer. Petitioner was not wearing his seatbelt and was bounced around inside the truck cab. After the accident, petitioner could barely walk, he had a bump on his head, his shoulders and chests were sore. Petitioner did not leave in an ambulance for treatment as he was afraid of losing his job. However, petitioner was taken from the scene by respondent's representative to the hospital for a drug test only.

Hours later, petitioner's supervisor, Douglas Kilbright, drove petitioner back to Ohio where he received treatment at the hospital. At the hospital, petitioner complained of a headache, as well as pain in his shoulders, chest, left knee and left elbow. He had a CT scan of the brain. Petitioner was treated and discharged from the hospital with a sling for a broken elbow

Petitioner had seen his family doctor, Dr. Sailors, in 2006 for an automobile accident. He had injured his neck and shoulders in the 2006 accident. He was treated by Dr. Sailors for two years after the 2006 accident. Dr. Sailors referred petitioner to a pain doctor, Dr. Demangone. Dr. Demangone performed cervical and lumbar injections. Petitioner had no treatment from November, 2006 until January 2008 to his neck and back. In January, 2008, petitioner received another cervical injection and then another in August, 2008. In January, 2009, petitioner slipped and fell on ice and injured his right wrist. He had also broken his right wrist in 2000.

Petitioner last saw orthopedist, Dr. John Hinson, in March [2016] in Florida. Petitioner received an injection in the left shoulder in March 2016. Petitioner was restricted by Dr. Hinson to light duty work; lifting no greater than five pounds. Petitioner discussed with Dr. Hinson the job opportunity of helping elderly people get to the hospital. Petitioner was scheduled to return to see Dr. Hinson on June 24, 2016. Petitioner may need to get another injection into the shoulder at that time. He was also to have physical therapy, but it has not been authorized by the insurance company. The insurance company was not authorizing equipment prescribed by Dr. Hinson; which is a similar device as a TENS unit.

Petitioner received physical therapy at Cleveland Clinic. He was also referred at the end of June, 2014, to Dr. Cordona, a neurologist at Cleveland Clinic, due to headaches and nightmares. Before the accident, petitioner had headaches but did not have any sleep issues. He admitted to having prior anger management issues. Dr. Cordona diagnosed petitioner as having a concussion and post traumatic symptoms.

In August, 2014 petitioner returned to Dr. Sailors; Dr. Sailors continued to recommend an MRI due to ongoing shoulder and neck problems. Petitioner had difficulties obtaining a letter of disability from Dr. Sailors' office. Petitioner was finally able to get a letter from Dr. Sailor dated September 12, 2014. Dr. Sailors wrote petitioner could return to work as long as he was provided with power steering. He was not provided with light duty work; instead he was terminated.

At petitioner's request, Dr. Sailors petitioner to a neurologist. As a result, he saw Dr. Rosemarie Zalar CMT at Dr. Koniarczyk; medication was prescribed. As of September 23, 2014, the neurologist indicated petitioner could not work.

On August 29, 2014, petitioner saw orthopedic surgeon, Dr. Mark Schickendantz as a referral from Dr. Sailors. Dr. Schickendantz injected petitioner's left shoulder and referred him for physical therapy. He received a second injection and additional therapy at the direction of Dr. Schickendantz. Therapy continued through April, 2015.

Petitioner was prescribed iMatch treatment by the neurologist but the treatment was not authorized. He also received a guided injection on April 30, 2015 by Dr. Schickendantz and continued physical therapy through June, 2015. On June 18, 2015, Dr. Schickendantz advised petitioner that non-operative treatment had been exhausted; surgery was recommended. On July 15, 2015, petitioner underwent arthroscopic surgery for debridement of a torn labrum. In August, 2015, physical therapy was prescribed.

On September 3, 2015, petitioner advised Dr. Schickendantz that he was moving to Florida. Dr. Schickendantz referred petitioner to see an orthopedist in Florida. Petitioner saw orthopedist, Dr. Hinson, in Florida in January, 2016. Petitioner was not able to get into see Dr. Hinson right away as there was a wait and he had to get insurance coverage.

Petitioner attended the deposition of Dr. An and Dr. Askenazi in Cleveland. Petitioner had seen both of these doctors at the request of respondent. Petitioner understood Dr. Askenazi believed petitioner had an adjustment disorder as a result of the rollover accident. Dr. Askenazi prescribed Cymbalta for depression.

Prior to the accident, petitioner denied taking medication or seeing a psychologist or psychiatrist for depression. Since the accident, petitioner has been taking Topamate, Cymbalta and a headache medicine.

Prior to the accident petitioner was able to perform his job; after the accident, he could not. Before the accident, petitioner was an active person, doing various things with his six children. Since the accident, petitioner has been depressed; has a hard time getting out of bed. He is seeing a psychiatrist for depression and a marriage counselor to save his marriage as his wife is working overtime to trying to support the family.

Petitioner testified the last temporary total disability payment he received was in September, 2014. However, petitioner confirmed he received a check in the amount of $19,613.06 in October, 2015.

Petitioner testified the video shows his job as a driver with respondent (PX.18). Petitioner identified his job description (PX.14).

Petitioner tried to get a variance due to physical impairment in order to drive a truck, and was unable to do so.

Petitioner was taken off work again by Dr. Schickendantz on October 2, 2014.

Petitioner last saw Dr. Hinson on March 29, 2016 and more physical therapy ordered. Petitioner was to return to Dr. Hinson in June, 2016 for another injection.

Petitioner underwent a commercial driver's fitness on July 24, 2012 at Concentra. He passed. If he violated respondent's drug and alcohol policy, he would be fired and it would be difficult for him to obtain future employment as a truck driver.

Petitioner is under the care of psychotherapy, Dr. Joe West, who is helping him with pain management and headaches. Petitioner would like to undergo a sleep study by Dr. Frank Conidi.

Petitioner confirmed he was to start a job driving older people as of June 1, 2016, providing the contract comes through.

On cross-examination petitioner confirmed Dr. Cordona and Dr. Sailors refused to give him an off-work note in August-September, 2014.

Petitioner confirmed his truck has power steering.

Hillcrest Hospital Records (PX.1)

The petitioner was seen on April 25, 2014 9:40 P.M. in the emergency room of Hillcrest Hospital. Petitioner reported he was in a rollover accident at 2:00 P.M. that day. His complaints recorded by the RN was that of a headache, right shoulder pain and left knee pain. He had no neck complaints. Diagnosis was right shoulder contusion, concussion, forehead abrasion, left knee contusion and left elbow possible cortical avulsion fracture. The emergency room doctor noted bilateral shoulder pain. The head CT scan was reported as normal. Petitioner had right shoulder, chest, right knee and left elbow X-rays that showed a possible small cortical avulsion fracture.

The diagnosis was concussion, right shoulder and left knee contusion, forehead abrasion and possible left cortical avulsion fracture. Norco and Ibuprofen was prescribed. Petitioner was instructed to follow up with Dr. Bloomfield and Dr. Violette.

Cleveland Clinic/Dr. Peter Evans & Dr. Luzma Cardona Records (PX.2)

According to these records, petitioner first saw hand orthopedist, Dr. Peter Evans, on May 1, 2014. Dr. Evans concluded the left elbow exam was benign; he removed the sling. Dr. Evans recommended petitioner follow up for the concussion.

Petitioner was seen by neurologist, Dr. Cardona on June 27, 2014, with complaints of severe headaches, difficulty sleeping, memory and temper problems. He was referred for a neuropsychological exam.

The neuropsychological evaluation was carried out by Dr. Richard I. Naugle, PhD. No significant compromise was found; the cognitive lapses were not attributable to neurocognitive disorder, but rather to headache pain, mild depression or situation stress. According to Dr. Naugle, the complaints would likely resolve when the pain, depression and fatigue were addressed.

Petitioner was seen by Dr. Cardona on July 25, 2014 for headaches. iMatch program was recommended. Dr. Cardona wrote two notes authorizing petitioner off work from the day of accident through August 31, 2014.

Dr. Frank G. Sailors and Associates Records (PX.3)

The records reflect petitioner was first seen by Dr. Sailors after the accident on April 29, 2014. He had complaints of a headache, left shoulder and arm pain, bilateral knee pain and chin pain. He reported a lot of stiffness. He was diagnosed with a concussion and various contusions. He was referred to orthopedic surgeon due to arm pain. Ibuprofen and Norco was prescribed.

He returned to Dr. Sailors on May 23, 2014 with bilateral shoulder strain, sternal pain, headache and left knee pain. He returned on July 2, 2014 with headache complaints and cervicalgia. Dr. Sailors suggested work hardening in order to get petitioner back to work. Bilateral shoulder MRIs were ordered. On August 20, 2014, petitioner returned to Dr. Sailor with cervical complaints. A cervical MRI was ordered.

The left shoulder MRI of August 26, 2014 showed rotator cuff tendinosis. The right shoulder MRI of September 4, 2014 showed osteoarthritis of the glenohumeral joint with degenerative tear of the posterior labrum and full-thickness chondral loss involving the posterior glenoid, as well as mild supraspinatus and infraspinatus tendinosis. The cervical MRI of September 5, 2014 revealed mild degenerative changes of the cervical spine.

Petitioner received an injection of Toradol on September 9, 2014.

On September 22, 2014 Dr. Sailors determine petitioner could return to work with no use of his arms above the head and no prolong use of shoulder for an extended period of time.

Cleveland Clinic Rehabilitation and Sports Therapy Records (PX.4)

The records confirm petitioner received physical therapy from June 6, 2014 through October 10, 2014 for neck and shoulder pain.

Cleveland Clinic/Mentor Family Health /Drs. Koniarczyk and Rubin Records (PX.5)

According to these records, petitioner was first seen at Mentor Family Clinic by CNP Rosemarie Zalar on September 23, 2014 for treatment of his post-concussion syndrome. The diagnosis was post-concussion syndrome, shoulder pain, arm numbness, headache and PTSD. Petitioner was ordered off work until evaluated by a neurologist.

Petitioner was seen by Dr. Michael Koniarczyk on October 16, 2014 for ongoing headaches. Dr. Koniarczyk believed the condition was the result of the neck strain rather than post-concussion.

On November 10, 2014 petitioner was evaluated by Dr. Sheila Rubin. Petitioner declined the iMatch program, recommended by Dr. Rubin for cognitive deficit, as he believed his condition was improving. He admitted he had prior tension headaches. He complained of nightmares. Dr. Rubin recommended occipital trigger point injections. Dr. Rubin believed he may have PTSD based upon the nightmares from the accident.

Petitioner followed up with Dr. Koniarczyk on November 17, 2014. On December 15, 2014, petitioner returned to Dr. Koniarczyk for headaches. He returned to the clinic on December 15, 2014 due to increased headaches and was given a Toradol injection.

On March 4, 2015 petitioner saw Dr. Koniarczyk due to an upper respiratory infection.

On May 5, 2015 he saw Dr. Koniarczyk as follow up for depression/headaches.

Cleveland Clinic/Dr. Deborah E. Tepper Records (PX.6)

These records include a report from Dr. Tepper dated December 4, 2014 indicating petitioner should participate in the iMatch program at the Cleveland Clinic to treat his headaches. Dr. Tepper did not believe petitioner was capable of returning to work as a truck driver.

Petitioner returned to Dr. Tepper on April 17, 2015. Dr. Tepper again recommended the iMatch treatment.

Cleveland Clinic Rehab & Sports Therapy Records (PX.7)

The records confirm petitioner received physical therapy to his shoulder from February through August, 2015.

Cleveland Clinic/Dr. Mark Schickendantz Records (PX.8)

These records indicate petitioner was self-referred to Dr. Schickendantz on October 2, 2014 due to bilateral shoulder pain. Dr. Schickendantz authorized petitioner off work. He returned on April 30, 2015 and received an injection. He returned on June 18, 2015 with increased pain in the left shoulder. Surgery was prescribed.

Petitioner underwent arthroscopic surgery on July 15, 2015 by Dr. Schickendantz due to osteoarthritis, torn labrum and subacromial bursitis of the left shoulder. Petitioner followed up with Dr. Schickendantz on July 30, 2015; he was to remain off work. On September 3, 2015. He was released to return to work with a 10-pound weight restriction. Petitioner advised he was moving to Florida in two weeks. Dr. Schickendantz advised petitioner to continue with his rehabilitation and follow up with an orthopedic surgeon in Florida.

Maramount Hospital Records (PX.9)

The records are that of the arthroscopic surgery performed by Dr. Schickendantz on July 15, 2015.

IWP Bills (PX.10)

The total amount claimed is $11,553.67 for the period from September 5, 2014 through August 12, 2015.

Cleveland Clinic Bills (PX.11)

The total hospital charges claimed are $29,727.04. These charges include treatment prior to the work accident on December 31, 2013, and similar tests performed on November 7, 2014 which are not supported by any medical records introduced. Also, petitioner included a claim for

treatment on March 4, 2015 for an upper respiratory infection, as well as bills related to his April 3, 2015 colonoscopy.

The total physicians' charges claimed are $29,116.00. However, these charges include treatment by Dr. Wu for the April 3, 2015 colonoscopy (including Dr. Wu's exam on March 19, 2015.) Additionally, these include a charge by Dr. Koniarczyk's March 4, 2015 treatment of petitioner's upper respiratory infection.

A final bill submitted is the bill from the emergency room visit on the day of the accident in the amount of $6,586.05; however, it appears this bill was paid.

Out of Pocket Medical Bills (PX.12)

The total out of pocket expense claimed is $470.00 plus mileage to and from treatment by his personal physicians and therapists. These co-pays were included as part of Petitioner's Exhibit 11, expect for the $15.00 bill from Innovative Health Services for the arm sling received at the emergency room on April 25, 2014.

Photos of Truck after accident (PX.13)

Petitioner's Job Description (PX.14)

The job description includes the essential requirements of the job and indicates petitioner may need to lift, push or pull up to 50 pounds.

Petitioner's Medical Exam for Driver's Fitness (PX.15)

This exam was performed on July 24, 2012 and determined petitioner was fit to drive.

A & R Transport Video (PX.18)

The video shows individuals discussing working for respondent.

Palm Beach Orthopaedic Institute/Dr. John Hinson Records (PX.19)

According to these records, petitioner was first seen by Dr. Hinson on January 28, 2016 for left shoulder complaints. His left shoulder was injected. Dr. Hinson discussed possible future shoulder replacement. Dr. Hinson released him to work with a five-pound lifting restriction and no overhead work.

The exhibit includes a $3,275.00 bill for services rendered from January 28, 2016 through March 29, 2016.

Quality Performance Rehab Records (PX.20)

Petitioner received physical therapy from October, 2015 through February, 2016 to his left shoulder. The exhibit includes a $3,311.62 bill for services rendered.

Dr. Francis Xavier Conidi, Neurologist Records (PX. 21)

These records indicate petitioner was first seen by Dr. Conidi on February 8, 2016 for headaches. Petitioner reported a thirty-year history of headaches, but has had different type of headaches since the work accident of April 25, 2014. Dr. Conidi recommended a sleep study. He returned for follow up on March 29, 2016 and April 21, 2016.

The exhibit includes the $1089.00 bill from Dr. Conidi.

Petitioner's Personnel Record (PX. 23)

The records are duplicate of PX.14 and PX.15.

Dr. Nicholas Ahn August 10, 2015 Deposition (RX 1)

Dr. Nicholas Ahn testified in behalf of respondent via deposition on August 10, 2015 (RX. 1.p.10). Dr. Ahn is a board certified orthopedic surgeon (See Dr. Ahn CV).

Dr. Ahn examined the petitioner on November 12, 2014 (RX.1, p. 13).

Dr. Ahn reviewed the cervical MRIs from February 8, 2006 and September 5, 2014 and determined there was mild degenerative changes without significant compression or stenosis. There was also a disc osteophyte budge (sic) at C5-6. The findings on both MRIs were similar with no acute findings (RX.1, p. 17).

The MRI of the left shoulder demonstrated rotator cuff tendinosis, but no acute findings (RX.1, p.18). Dr. Ahn concluded there was no post-traumatic changes after the accident (RX.1, p.19). Dr. Ahn reviewed prior medical records from after a 2006 accident which showed petitioner complained of a severe headache, neck pain and right shoulder discomfort (RX.1, p.19). The records also showed petitioner had neck and left arm and shoulder complaints from 2007 through 2009 (RX.1, pp-19-20). The records show petitioner injured his right shoulder due to a fall on ice at work in 2009 (RX.1, p. 20). Dr. Ahn concluded petitioner had chronic neck and shoulder pain before 2014 accident (RX.1, pp. 20-21).

Dr. Ahn examined petitioner on November 12, 2014 (RX.1, 21). Dr. Ahn found petitioner to be reliable and compliant (RX.1, p. 21). The exam was negative except for a very positive Tinel's sign over right greater occipital nerve, which is consistent with greater occipital neuralgia or neuritis (RX.1, pp.21-22). Dr. Ahn believed the neuralgia developed after the accident, which Dr. Ahn believe were related to the accident (RX.1, pp. 22-23).

Dr. Ahn believed petitioner sustained cervical sprain and strain, left knee strain and sprain; bilateral shoulder sprain and strain and the left elbow strain and sprain as a result of the accident (RX.1, p. 24). Dr. Ahn agreed that despite the injuries, the only positive finding at the time of his examination of petitioner was the positive Tinel sign over the greater occipital nerve (RX.1, p.25). Dr. Ahn did not believe petitioner had a concussion (RX.1, p.26). Dr. Ahn did not believe petitioner had evidence of an aggravation of any pre-existing condition (RX.1, p.27). Dr. Ahn believe petitioner would have reached maximum medical improvement from the sprains and strains within six weeks after the accident (RX.1, pp.27-28). Therefore, Dr. Ahn believed any treatment related to the sprains and strains after June 6, 2014 were not related to the work accident (RX.1, p.28). Dr. Ahn believe petitioner could return to work as of June 6, 2014 (RX.1, p.30).

On cross examination Dr. Ahn agreed the emergency room records on the day of the accident from Hillcrest Hospital indicated petitioner had complaints of bilateral shoulder pain (RX.1, p.38). Dr. Ahn agreed the emergency records of Hillcrest Hospital indicated petitioner had an X-ray of the left shoulder and left with a sling on the left arm (RX.1, pp.37-39).

Dr. Ahn testified he is a spine surgeon and does not perform elective shoulder surgeries (RX.1, p.48). Dr. Ahn agreed Dr. Schickendantz is an excellent shoulder surgeon who would do the right thing for petitioner if he performed shoulder surgery (RX.1, p.56). Dr. Ahn was not sure when petitioner could return to work (RX.1, p.63). Dr. Ahn did not know if he was provided records from Dr. Schickendantz (RX.1, p. 76). Dr. Ahn testified that, at the time of his exam, petitioner was not a shoulder surgical candidate but could not rule it out in the future (RX.1, p.83).

Dr. Ahn testified that typically a recovery from the debridement of a torn labrum and chondroplasty of the glenoid and subacromial bursa takes three to four months (RX. 1, pp.83-84).

The deposition came to an end due to time constraints and no objections were raised by either party as to the incompleteness of the deposition at the time it was admitted.

Galit Askenanzi Ph.D. August 11, 2015 Deposition (RX.2)

Dr. Galit Askenanzi, a forensic neuropsychologist, testified in behalf of respondent via deposition on August 11, 2015 (RX.2, p. 4). Dr. Askenanzi examined petitioner on November 13, 2014 and December 2, 2014 (RX.2, p.7). At the time of his exam by Dr. Askenanzi, petitioner admitted he had improvement over time with his memory, speech issues and cognitive difficulties (RX.2, p.9). Petitioner admitted he had headaches prior to the work accident (RX.2, pp.9-10).

Petitioner claimed to have no prior mental health issues before the accident (RX.2, p.10). The records reflect petitioner had prior issues with temper and depression (RX.2, pp10-11).

Dr. Askenanzi testified petitioner did not meet the criteria for PTSD despite nightmares and sleep disorder (RX.2, p.13). Dr. Askenanzi did not find petitioner had any observable cognitive issues, but exhibited mood symptoms (RX.2, p.16). Overall petitioner's tests were within normal limits (RX.2, p.18). Dr. Askenanzi determined petitioner cognitive emotional functioning seemed pretty much intact except for complaints of difficulty adjusting to not working at the time; or adjustment reaction (RX.2, pp.20-21). Dr. Askenanzi considers an adjustment disorder chronic if in excess of six months (RX.2, p.22).

Dr. Askenanzi believed petitioner would benefit from psychiatric medication evaluation to treat his symptoms (RX.2, p.23-24; 47-48). No psychotherapy or any cognitive or speech therapy was recommended (RX.2, p.24). Dr. Askenanzi believed petitioner would be capable of returning to his prior job as a truck driver (RX.2, pp. 24-25). Dr. Askenanzi did not believe petitioner had a concussion (RX.2, p.32). Dr. Askenanzi did not find petitioner was malingering (RX.2, p.36).

Pain Management Association Records (RX.3)

These records confirm petitioner received treatment at Pain Management Association starting in March, 2006 to November, 2006 for lower back and neck pain and again from January, 2008 to October, 2008.

Trice Chiropractic Clinic (RX.4)

These records confirm petitioner received chiropractic care from February through August, 2006 for neck and back pain.

Cervical MRI of February 8, 2006 showed only a one mm central disc bulge at C5-6 without evidence of significant stenosis, cord compression or nerve root impingement (P.83).

Payment History (RX.9)

The records confirm the total amount claimed paid by respondent as of April 11, 2016 for medical expenses and disability payments.

Dr. Sailors' September 12, 2014 letter (RX.12)

Dr. Sailors wrote that petitioner was asking for a letter of disability. However, Dr. Sailors did not know the basis upon which petitioner was making the claim for disability. Dr. Sailors believed petitioner could return to work driving as long as it was with power steering.

Dr. Luzma Cardona August 27, 2014 Office Note (RX.13)

The office notes indicated petitioner called Dr. Cardona's office on August 27, 2014 requesting a disability note; Dr. Cardona refused to complete one and referred petitioner to his primary care doctor.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

F. 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 finding:

Petitioner sustained multiple contusions, including his right knee and shoulder, a concussion and a torn labrum and subacromial bursitis superimposed upon osteoarthritis of the left shoulder. Petitioner also suffered a possible cortical avulsion fracture of the left elbow.

The medical records Dr. Peter Evans on May 1, 2014 suggest petitioner did not have any residual problems from the left elbow fracture.

Petitioner's testimony and the medical records indicate petitioner does not have any ongoing problems with his right shoulder from the work accident.

The Arbitrator find's petitioner has no lasting cervical disorder as a result of the work accident.

Dr. Nagle, who performed a neuropsychological examination on July 16, 2014 reported petitioner did not have any significant cognitive compromise but was rather attributable to headache pain, mild depression or situational stress. Dr. Askenanzi attributed petitioner's symptoms to adjustment disorder from not working and agreed petitioner. Dr. Askenanzi agreed petitioner would benefit from psychiatric medication evaluations to treat petitioner of his symptoms. According to Dr. Rubin's November 10, 2014 records, petitioner declined iMatch treatment for his cognitive deficit as his condition was improving. Dr. Ahn reported petitioner had a positive Tinel sign over the right greater occipital nerve, which was consistent with greater occipital neuralgia or neuritis. Based upon the foregoing, the Arbitrator finds petitioner's ongoing headaches relative to the occipital neuralgia or neuritis were caused by the work accident.

The Arbitrator finds petitioner's ongoing problems relative to the left shoulder, which necessitated the surgery performed by Dr. Schickendantz on July 15, 2015, and injections done by Dr. Hinson in 2016, were caused by the work accident. The Arbitrator makes this finding based upon the fact petitioner had complaints of bilateral shoulder complaints, as recorded by the emergency room doctor on the day of the accident on April 25, 2014. Although x-rays were not performed on the left shoulder in the emergency room on the day of the accident, left shoulder X-rays had been ordered and then cancelled. Petitioner also complained of left shoulder problems to Dr. Sailors as of April 29, 2014. The August 26, 2014 MRI of the left shoulder showed rotator cuff tendinosis for which petitioner sought treatment with Dr. Schickendantz.

The Arbitrator makes this finding despite the opinion of Dr. Ahn as Dr. Ahn, by his own admission is a spine surgery, rather than a shoulder specialist. Dr. Ahn agreed Dr. Schickendantz was an excellent shoulder surgeon. Dr. Ahn conceded he may have not been provided with Dr. Schickendantz's records and agreed surgery could not be ruled out at the time of his examination of petitioner on November 12, 2014. Dr. Ahn also agreed Dr. Schickendantz was in the best position to determine whether surgery was necessary having physically seen the injury.

J. In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

(The Arbitrator notes petitioner attached a list of medical bills that he proposed should be included in the award. Unfortunately, this list included bills from Cleveland Clinic for treatment that pre-dated the work accident, treatment for unrelated conditions such as URI and colonoscopy, treatment unsupported by medical records and duplicate charges for physical therapy on March 19, 2013 that was later reversed by the Cleveland Clinic.)

Based upon the evidence, the Arbitrator finds the following medical bills are reasonable and necessary to cure petitioner of his work injuries and awards same:

$2,650.00 to Palm Beach Orthopaedic Institute for treatment on January 28, 2016 (as there were no medical records from the March 29, 2016 visit to substantiate the bill); $3,311.62 to Quality Performance Rehabilitation; $1,089.00 to Dr. Francis Xavier Conidi; $11,553.67 to Injured Workers' Pharmacy.

As for the Cleveland Clinic bills, the Arbitrator awards $28,222.14 for the hospital portion of the bill and $25,869.00 for the physician's portion of the bill. In addition, the Arbitrator awards the bill from emergency treatment of April 25, 2014, in the amount of $6,585.05 (if not already paid).

The Arbitrator excluded the following portions of the Cleveland Clinic claimed: the treatment on December 31, 2013 as it was incurred before the accident; October 16, 2014 and December 4, 2014 as there are no medical records to support these visits; November 7, 2014, as there were no medical records to support this treatment and it appears from the bill it is for similar treatment rendered on December 31, 2013; March 4, 2015 as the visit relates to an upper respiratory infection and treatment by Dr. Wu on March 19, 2015, and April 3, 2015, and the hospital stay for April 3, 2015, for petitioner's colonoscopy.

With the exception of the $15.00 bill for the sling, petitioner's out of pocket expense were included in the award for the medical bills from Cleveland Clinic. The Arbitrator therefore awards the additional sum of $15.00 to petitioner.

There is no provision within the Act which warrants an award for mileage to and from the medical providers selected by petitioner. Therefore, the claim for mileage is denied.

All bills are to be paid in accordance §8 and §8.2 of the Act.

Respondent to be given credit for all payments made as reflected in Respondent's Exhibit 9, or upon proof of any other payment.

K. In support of the Arbitrator's decision in regard to prospective medical care, the Arbitrator finds the following:

The Arbitrator, having found petitioner sustained injury to his left shoulder which necessitated ongoing treatment, that petitioner is receiving from Dr. Hinson, is reasonable and necessary to cure petitioner of his work injury and awards such treatment as prescribed by Dr. Hinson after March 29, 2016, with the exception of the equipment described by petitioner as a device similar to a TENS unit as there was no prescription for same introduced into evidence.

The Arbitrator finds petitioner needs ongoing psychiatric prescription medication as recommended by respondent's doctor, Dr. Askenanzi, to treat his head symptoms as a result of the work accident and awards same.

The Arbitrator finds the sleep study, as ordered by Dr. Conidi, is necessary to cure him of his work injuries as petitioner has had ongoing nightmares and sleep disruption since the work accident, and awards the cost of same.

No further costs for iMatch is being awarded as petitioner admitted his condition was improving without it.

L. In support of the Arbitrator's decision with regard to TTD and maintenance benefits, the Arbitrator finds the following:

The evidence supports a finding petitioner was temporarily totally disabled from the date of the accident until September 22, 2014 when Dr. Sailors released petitioner with restrictions.

Thereafter, petitioner began treatment with Dr. Schickendantz on October 2, 2014, who kept petitioner off work until September 3, 2015. At that time, Dr. Schickendantz released petitioner to return to work with a ten-pound weight restrictions.

Petitioner came under the care of Dr. Hinson, in Florida, on January 29, 2016. Dr. Hinson released petitioner to return to work with a five-pound lifting restriction as of January 29, 2016. There is no further indication of petitioner's ongoing disability after that date.

Dr. Ahn testified estimated recovery time for the type of shoulder surgery petitioner underwent would be three to four months.

As for the head injury, Dr. Koniarczyk indicated petitioner could not work as of September 23, 2014. There is no record of any treatment relative to his head injury after May 5, 2015, when he saw Dr. Koniarczyk, until he saw Dr. Conidi in Florida on February 8, 2016. Dr. Conidi's records does not discuss petitioner's ability to return to work.

It appears from the evidence provided, petitioner proved he was temporarily totally disabled from April 26, 2014 through January 29, 2016. Therefore, the Arbitrator awards temporary total disability from April 26, 2014 through January 29, 2016, which is 92 weeks at the rate of $726.33 per week.

The evidence suggest petitioner reached maximum medical improvement as of January 29, 2016. The evidence does not indicate petitioner made a demand for vocational rehabilitation or performed his own job search. Therefore, his claim for maintenance is denied.

M. In support of the Arbitrator's decision with regard to penalties and fees, the Arbitrator finds the following:

Petitioner was receiving treatment for both the shoulder and head injury in Ohio and then in Florida when he moved. The evidence indicates petitioner had a difficult time obtaining a letter of disability from his own physician, Dr. Sailors, until September 22, 2014. There is no evidence petitioner provided proof of disability from Dr. Schickendantz when he began treatment on October 2, 2014. As petitioner was receiving treatment in Ohio and Florida, the respondent's ability to obtain medical records on its own was limited.

Respondent had petitioner examined by Dr. Ahn on November 12, 2014 who opined petitioner was capable of return to work within six weeks after the accident. Dr. Ahn also opined petitioner should have recovered within three to four months after his July 15, 2015 surgery. Petitioner was also examined by Galit Askenzai Ph.D. on November 13, 2014 and December 2, 2014 who believed petitioner was capable of returning to work.

Although the evidence was insufficient to defeat the claim for temporary total disability, it is sufficient to defeat the claim for penalties and attorneys' fees.

As petitioner failed to prove he made a demand for vocational rehabilitation or performed his own job search, no maintenance benefits are due.

For these various reasons, the Arbitrator finds respondent's actions were not unreasonable and vexatious and denies an award of penalties or attorneys' fees.

O. **In support of the Arbitrator's decision with regard to vocational rehabilitation, the Arbitrator finds the following:**

Petitioner, by his own admission, does not require vocational rehabilitation as he is scheduled to start a position on June 1, 2016 driving medical patients.

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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIMOTHY CASSENS,

Petitioner,

vs. NO: 16 WC 13153

TCH CONSTRUCTION, INC.,

Respondent.

18IWCC0408

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, incurred medical expenses, TTD, and PPD, and being advised of the facts and law, reverses the Decision of the Arbitrator, which is attached hereto and made a part hereof, as stated below.

Petitioner and a coworker, Jose Sandoval ("Sandoval"), on January 21, 2016, were employed by Respondent as carpenters and were tasked to perform work at the residence of Respondent's Vice President, Mark Walker ("Walker"). Petitioner claims to have slipped on the ice at the worksite while walking to a boathouse where construction materials were stored and fell onto his right elbow. Petitioner testified that it was his intention to lock the boathouse.

The presiding Arbitrator found Petitioner failed to prove by a preponderance of the evidence that he sustained injuries that arose out of and in the course of his employment with Respondent on January 21, 2016. In so finding, the Arbitrator concluded "the sheer volume of the Petitioner's varied and inconsistent histories of the January 21, 2016, incident coupled with the contradictory testimony and documents undermine his claim that he suffered accidental injuries arising out of and in the course of his employment." The Commission acknowledges

Petitioner's medical records conflict with the history Petitioner presented at his arbitration hearing but finds Petitioner's testimony credible and reconciles to the Commission's satisfaction any discrepancy between the history Petitioner proffered and the histories contained in Petitioner's medical record.

Petitioner testified to slipping and falling while on the worksite. Sandoval, Respondent's only other employee at the worksite, did not contradict this testimony. Sandoval testified that he did not see Petitioner slip and fall and stated that he did not have his eyes on Petitioner all day. No witnesses were produced to contradict Petitioner's testimony.

Petitioner and Sandoval both testified that they spoke to each while working at the worksite that day, though their testimony diverged with respect to whether Petitioner slipping and falling was discussed. Petitioner testified that he told Mr. Sandoval about his fall. Sandoval testified that Petitioner did not say anything to him about falling on ice.

Petitioner testified that he reported the incident to Walker at 4:29pm on the day of the incident. Mr. Walker testified to speaking with Petitioner at that time and to the conversation being about Petitioner slipping and falling. Petitioner and Walker both testified to having a conversation earlier that day at about 2:56pm that did not touch upon Petitioner slipping and falling. Petitioner testified that he didn't inform Walker of his slipping and falling because his mind at that time was on what the HVAC workers who were working on the house found in the house.

The Arbitrator noted Petitioner's testimony and his medical records both made mention of a driveway. The Arbitrator also noted the medical records indicated that Petitioner fell in his own driveway. Petitioner testified that he told his medical providers that he fell on "the" driveway and it was subsequently interpreted that he was speaking of his own driveway. Julie Cassens ("Cassens"), Petitioner's wife, testified that Petitioner never fell in their own driveway.

The Commission finds Petitioner to be credible and finds, further, the discrepancies between Petitioner's testimony and his medical records and the testimony of both Walker and Sandoval to be not so significant as to find Petitioner otherwise. Accordingly, the Commission finds Petitioner satisfied his burden of proving that the accident he experienced on January 21, 2016, and the resultant injury to his right upper extremity arose out of and in the course of his employment with Respondent.

The injury to Petitioner's right shoulder resulted in him presenting to Mercy Harvard Hospital on the day of the accident. There, he was examined, underwent x-rays, and was discharged with a referral for him to his primary care physician. The following day, on January 22, 2016, he presented to the offices of his primary care physician, Family Medicine for McHenry County. He was seen by Katherine Galias, DNP, as his primary care physician was unavailable. She ordered Petitioner to undergo an MRI with an additional instruction for him to see Dr. Rolando Izquierdo, Jr., if the MRI revealed any damage to his right shoulder. The MRI was undertaken on January 26, 2016, and revealed multiple injuries to Petitioner's right shoulder.

Per the instruction given to him, he presented to Dr. Izquierdo on January 28, 2016.

Dr. Izquierdo examined Petitioner on January 28, 2016, and diagnosed him as having an either an unspecified tear of the rotator cuff or rupture of the right shoulder as well as a supraspinatus tear with retraction, also in the right shoulder. Dr. Izquierdo recommended Petitioner undergo a right shoulder arthroscopy with possible biceps tenodesis. That surgery was performed on March 18, 2018, and resulted in findings of a right shoulder large full-thickness rotator cuff tear, right shoulder subacromial impingement, and right shoulder bicipital tendinosis, partial thickness tearing and instability. These findings were treated with a right shoulder arthroscopic repair of the large full-thickness rotator cuff, right shoulder arthroscopic biceps tenodesis, and right shoulder arthroscopic subacromial decompression with anterior acromioplasty.

Postoperatively, Petitioner continued to treat with Dr. Izquierdo and concurrently underwent physical therapy at Poplar Grove Physical Therapy. Both Dr. Izquierdo's records and the physical therapy records revealed the steady improvement of Petitioner's right shoulder. By August 9, 2016, Petitioner no longer took pain medication and, by September 12, 2016, had 0/10 pain at rest and 3/10 pain with activity. As of September 12, 2016, Dr. Izquierdo recommended Petitioner continue with a home exercise program, gradually resume activities, and take a NSAID as necessary. Dr. Izquierdo released Petitioner from his care that day, offering to reevaluate Petitioner at Petitioner's convenience.

An element of Dr. Izquierdo's regimen for treating Petitioner was to preclude Petitioner from resuming his normal and usual work activities. From January 28, 2016, the day Petitioner was first seen by Dr. Izquierdo, through August 9, 2016, Petitioner was found capable of working only at a light duty physical demand level. Respondent was unable to accommodate Petitioner's limited capacity to work. Dr. Izquiedro released Petitioner to resume his normal and usual work activities without restrictions on August 9, 2016. Petitioner did not return to work for Respondent and, instead, opted to work as a carpenter for another employer.

Petitioner, as of the time of the arbitration hearing, had been working as a carpenter for another employer for a month-and-a-half. He testified to having a pain in his neck that he believes will be permanent and to having pain in his right shoulder when he awakens in the morning. He testified further that his shoulder will be very, very sore from using it all day. He treats this soreness with Ibuprofen and has not sought medical care for his shoulder since September 12, 2016.

The Commission, in addition to finding Petitioner's January 21, 2016, accident resulted in the injury to Petitioner's right shoulder, also finds the same accident resulted in Petitioner requiring the medical treatment as described above as well as being temporarily totally disabled from January 28, 2016, until August 9, 2016, also as described above. The Commission finds further Petitioner has residual symptomology that is construed to a permanent partial disability affecting Petitioner as a whole.

In reversing the Arbitrator with respect to accident and resultingly awarding Petitioner a benefit under Section 8(d)2 of the Act, the Commission determines Petitioner's level of disability by employing the factors as enumerated in Section 8.1(b) of the Act:

Section 8.1(b)(i) (Impairment Rating): As neither party submitted an impairment rating pursuant to Section 8.1(a) of the Act, the Commission places no weight on this factor.

Section 8.1(b)(ii) (Occupation of the Injured Employee): Petitioner was a foreman for Respondent but also performed the work duties of a carpenter for Respondent. Petitioner was working as a carpenter for Respondent at the time of his accident. Petitioner, upon being released to full work duty on August 9, 2016, elected to not return to work for Respondent but to work for another employer as a carpenter. Because Petitioner, in testifying at his arbitration hearing, failed to delineate how much time was spent in a supervisory capacity as a foreman versus how much time was spent as strictly a carpenter, the Commission cannot determine the physical impact Petitioner experiences working strictly as a carpenter as opposed to his former hybrid position as a foreman/carpenter. The Commission does, however, take into consideration Petitioner's abandonment of his position with Respondent in favor of a carpenter position for another employer for reasons not explained. Accordingly, the Commission places some weight on Petitioner's modestly changed job descriptions.

Section 8.1(b)(iii) (Age of the Injured Employee): Petitioner was 51-years old at the time of his accident. No testimony was offered as to how long Petitioner intended to work. The Commission is, therefore, unable to determine how long Petitioner will work with his permanent partial disability. The Commission, based on Petitioner's age at the time of his accident, presumes Petitioner will work another 10 to 15 years with his permanent partial disability weight. The Commission places some weight on this.

Section 8.1(b)(iv) (Future Earning Capacity): Petitioner suffered no diminution of his earning capacity as result of his permanent partial disability. His present and future earning capacity is controlled by the current union pay scale. The Commission places little weight on the factor.

Section 8.1(b)(iv) (Evidence of Disability Corroborated by Medical Records): The Commission does not conflate any testimony concerning any disability with the medical records. The Act requires the Commission to look to the medical records alone. Petitioner had completed physical therapy on August 4, 2016, and had been returned full duty work effective August 9, 2016. Petitioner's last medical record, dated September 12, 2016, note him experiencing 0/10 pain at rest and 3/10 pain with activity in his right shoulder and popping in the same. That record, and the August 9, 2016, record before it, noted that he took no pain medication. The physical examination recorded Petitioner's right upper extremity strength to be 5/5 on a 0-5/5 scale with no impairment of range of motion noted. The recommendation for Petitioner was for him to continue with the home exercise program and gradually progress with activities. The Commission places great

weight on Petitioner's medical records.

Reconciling Petitioner's as-testified-to current condition with his medical records, the Commission finds Petitioner testimony revealed some degree of embellishment as to his current condition. He testified to experiencing pain in his neck that he believed would be permanent. Dr. Izquierdo's record from August 9, 2016, had noted Petitioner indicated and/or found Petitioner had no neck pain and full range of motion of the cervical spine. The physical examination that was performed on September 12, 2016, recording findings of no neck pain and a neck that demonstrated full range of motion. This divergence between Petitioner's testimony and his medical records calls into question Petitioner's claim to waking up with pain in his shoulder and to his shoulder "being very, very sore" after a day's work, particularly as he told Dr. Izquiedro that he experienced on 3/10 pain with activity. That Petitioner, despite his as-testified-to current complaints, has not sought medical care after September 12, 2016, calls into question the actual extent of his permanent disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,091.21 per week for a period of 27-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $982.04 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 10% loss of the person as a whole

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $72,211.96 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 $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 29 2018
KWL/mav
O:05/01/18
42

Thomas J. Tyrrell

Michael J. Brennan

18IWCC0408

DISSENT

I respectfully disagree with the decision of the majority and agree with the Arbitrator that Petitioner failed to prove by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment on January 21, 2016. Accordingly, I would affirm and adopt the Arbitration Decision filed with the Commission on December 14, 2016.

The testimony of Sandoval and Walker is found to be more credible than the testimony of Petitioner and his wife, Cassens. Sandoval testified to having worked with Petitioner on the date of the claimed accident and was, at no time, told by Petitioner about any fall that he had experienced while working that day. He testified that he and Petitioner hung drywall after the time Petitioner purportedly hurt himself. He didn't notice Petitioner to be in any pain while hanging the drywall. He testified to learning that Petitioner's claimed workplace injury from Mark Walker, his and Petitioner's supervisor, almost two hours after he and Petitioner left the worksite for the day. Walker testified he spoke with Petitioner a few minutes before the end of the workday, at 2:56pm, but was not told of any accident or injury befalling. He testified of learning about the claimed accident and injury from Petitioner at 4:29pm on the day of the claimed accident. Neither Sandoval nor Walker were subjected to cross-examination.

Petitioner's testimony followed the testimony of Sandoval and Walker and, in part, only contradicted but did not refute the testimony of Sandoval. He testified that he told Sandoval about his fall after he returned from locking the boathouse. He testified that he could not raise his right arm after returning from the boathouse. Absent from the testimony was a claim that he informed Sandoval that he had, in fact, hurt himself in the fall and a denial that he helped Sandoval hang drywall after the time of the claimed fall. His testimony about what he told Walker did not contradict what Walker testified to but it was, in part, internally inconsistent. On direct examination, he testified that he did not tell Walker about his fall earlier in the day when they spoke at 2:56pm that day because he was thinking about what the HVAC workers had found on the jobsite. On cross-examination, however, he testified that he didn't tell Walker of his fall and injury because doing so would have put a "x" on his back. It was not elicited why he felt, after working for Respondent for over twelve (12) years, that reporting an injury would have been met with hostility. More significantly, uncertainty exists as to why he felt more comfortable telling Walker about the claimed fall and injury 4:29pm on the day of the claimed accident and injury than he did when he spoke to him only ninety (90) minutes earlier. He offered no explanation to explain why was less at risk of having the "x" on his back at 4:29pm than at 2:56pm.

Petitioner's testimony, in part, also contradicted that of Cassens. He testified that he fell while walking to the boathouse. Cassens, however, testified, on direct examination, that Petitioner told her that he had fallen while walking from the boathouse. On cross-examination, Cassens testified that it was her testimony that Petitioner had told him that he fallen while walking away from the boathouse. No attempt was made to reconcile the conflicting history in

their respective testimony.

Recognizing the possible conflict of interest of all those who testified, the most credible evidence in this case are the medical records. In no instance does Petitioner relate his symptoms to anything related to work. He presented to Mercy Harvard Hospital approximately four hours after the claimed injury where it was reported that he slipped on ice in his driveway. The following day, on January 22, 2016, he presented to both OrthoIllinois and to Family Medicine for McHenry County. At both, he was recorded as falling in his driveway. When asked about these histories at the arbitration hearing, Petitioner testified that he told the personnel at Mercy Harvard Hospital and Dr. Izquierdo simply that he fell in simply "the" driveway. Credulity is presumed with that claim.

Petitioner's medical records all imply that he fell in his own driveway. Petitioner counters the history recorded in the medical records with only his testimony and that of his wife. Petitioner testified that he told his medical providers that he fell on "the" driveway. It is found unusual that Petitioner did not provide a more specific description or location of the driveway on which claimed to have fallen on given the proximity in time between the claimed fall and the reporting said fall. Cassens, Petitioner's wife, testimony as to the claimed fall was simply a recitation as to what her husband purportedly told her. Her testimony that Petitioner did not fall on their driveway leaves open the possibility that Petitioner fell at a location other than in his own driveway.

Given Petitioner's failure to report any fall to Walker when they spoke at 2:56pm on January 21, 2016, and Sandoval's being unaware that Petitioner had been injured at any time prior to 4:45pm that day despite them working together from 7:00am until 3:00pm on January 21, 2016, it appears more likely than not, that if Petitioner fell on January 21, 2016, he did so away from the jobsite. This would explain why Petitioner did not tell Walker about being injured when they spoke at 2:56pm or why Sandoval wasn't aware that Petitioner was injured when they parted company. It would explain why Petitioner offered the testimony that he told his medical providers of falling simply onto "the" driveway. It would be consistent with Cassens' testimony that Petitioner did not fall onto their driveway.

More significant than the discrepancies between Petitioner's testimony and those of Sandoval and Walker is the discrepancy between Petitioner's testimony about the current condition and Dr. Izquierdo's medical records. Before the Arbitrator, as noted by the majority, Petitioner complained of having permanent neck pain. Dr. Izquierdo's medical records, from his April 21, 2016, examination of Petitioner through his final examination of Petitioner on September 12, 2016, there were no complaints of or finding by Dr. Izquierdo of neck pain. Quite simply, Petitioner is found to have misrepresented the existence of neck pain before the Arbitrator for no apparent reason. If Petitioner is so inclined to make that misrepresentation, it is not inconceivable Petitioner would also misrepresent how he came to injure his right shoulder for secondary gain.

Taken as a whole, the evidence does not support a finding in favor of Petitioner. As the

Arbitrator concluded, "the sheer volume of the Petitioner's varied and inconsistent histories of the January 21, 2016, incident coupled with the contradictory testimony and documents undermine his claim that he suffered accidental injuries arising out of and in the course of his employment." I agree with the Arbitrator's conclusion and, for that reason, respectfully dissent with the opinion of the majority.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CASSENS, TIMOTHY
Employee/Petitioner

Case# **16WC013153**

TCH CONSTRUCTION INC
Employer/Respondent

18IWCC0408

On 12/14/2016, 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 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0560 WIEDNER & McAULIFFE LTD
KENDRA G GARSTKA
ONE N FRAKLIN ST SUITE 1900
CHICAGO, IL 60606

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

Timothy Cassens
Employee/Petitioner

v.

TCH Construction Inc.
Employer/Respondent

Case # 16 WC 13153

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Woodstock**, on **November 4, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 21, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$85,110.24**; the average weekly wage was **$1636.74**.

On the date of accident, Petitioner was **51** years of age, *married* with **0** dependent children.

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

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

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

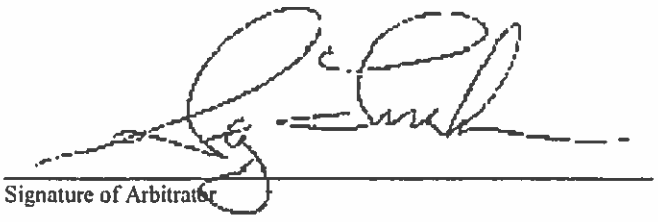
Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

BECAUSE THE ARBITRATOR FINDS THAT PETITIONER FAILED TO PROVE BY THE PREPONDERANCE OF THE EVIDENCE THAT HE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT ON JANUARY 21, 2016, THE CLAIM FOR COMPENSATION IS HEREBY DENIED.

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

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



Signature of Arbitrator

December 14, 2016
Date

DEC 14 2016

Statement of Facts

Petitioner Timothy Cassens testified that he had been a carpenter for 30 years. He had worked for Respondent for 12 1/2 to 13 years. On January 21, 2016, he was working at Respondent's owner, Mark Walker's residence in Delavan, Wisconsin from 7:00 AM to 3:00 PM. He testified that at about 1:30 PM, he was going to lock the boat house where the materials were stored. He went to retrieve a tool from his truck that was parked in the driveway of Walker's residence, when he slipped and fell on ice. Petitioner testified that the temperature was very cold and there had been snow the night before and it was very icy. The ice on the driveway was hard. Petitioner testified that he pulled himself up, locked up the boat house, and went back to the house. Petitioner testified that he told his fellow employee Jose Sandoval that he could not raise his arm while working on a piece of drywall on the ceiling. He testified he told Jose that he fell on the ice.

Jose Sandoval testified that he has been employed by Respondent as a carpenter for 12 years. He was working on Mr. Walker's house in Delevan on January 21, 2016. On that day, he was working with Petitioner. There was also someone from another company there, but no other employees of Respondent. He finished work that day at 3:00 PM. He testified that Petitioner did not mention anything about a slip and fall on ice. He did not see Petitioner slip and fall. He testified that there was a boat house on the premises where they kept some materials. Petitioner was not in his vision all day. He testified that there was snow on the ground. He testified that he worked with Petitioner that afternoon. Petitioner did not mention he was having problems with his shoulder or needed assistance. Mr. Sandoval never offered to finish the drywall or assist Petitioner.

Petitioner testified he spoke with Mark Walker multiple times on the morning of January 21, 2016 to discuss the job. He testified to a telephone conversation with Mark Walker at 2:56 PM. Petitioner testified that he never mentioned anything about the slip and fall. He testified that his mind was on the HVAC issues. He testified that he was getting ready to go home and thought by icing his shoulder that night, he would be better the next morning. He testified to slip and falls and injuries on the job all the time as a carpenter. He had never filed a Worker's Compensation claim before. He testified that the reason he did not mention the injury to Mark Walker during the phone call was because it was his belief that any time you have a Workers' Compensation claim you get an "X" on your back.

Petitioner testified that after he left the job site, he drove to his wife's office in Poplar Grove. That was his daily routine during tax season, to pick up his 6 year old grandson. He also testified that because his shoulder was hurting, he wanted his wife to have a look at it. He testified that he arrived at his wife's office at approximately 4 PM. The drive from Delavan, WI to Poplar Grove, IL took 45 minutes to an hour. He testified that he called Mark Walker at 4:29 PM and told him that he slipped and fell on the ice at Walker's residence and hurt his shoulder and was going to get it checked out because of the intensity of the pain. He testified that Mr. Walker told him to keep him informed. He testified from there he went to the emergency room at Mercy Harvard Hospital.

Mark Walker testified that he is the vice-president of Respondent. Petitioner was working a job for Respondent as his personal residence in Delevan, WI on January 21, 2016. He was working with Jose Sandoval finishing up some flooring and a little bit of drywall. He testified to 4 telephone conversations with Petitioner on that morning about job related issues. He testified he spoke with Petitioner at 2:56 PM about the job. Petitioner did not mention anything about an injury. He spoke with Petitioner at 4:29 PM. Petitioner told him he slipped and fell at work and was going to get checked out. Mr. Walker testified he asked Petitioner why he did not tell him about this at 3:00 PM and why he didn't tell the guy he was working with. He testified that Petitioner did not

respond. Mr. Walker testified he reported the injury to his insurance carrier the next day, stating the accident was in question.

Jose Sandoval testified that he received a call from Mr. Walker at 4:45 PM. Mr. Walker told him that Petitioner called and told him he has fallen. Mr. Sandoval told Mr. Walker he did not know anything about it because Petitioner had not commented about anything to him.

Julie Cassens testified that Petitioner is her husband. She owns an H & R Block tax office in Poplar Grove, Illinois. During January, her daughter works with her, so her 6 year old grandson comes to the office after school. She testified that Petitioner would come over after work to see if he needed to take her grandson out or home. On January 21, 2016, Petitioner arrived at 4:00 PM. She could see he was in pain. She testified that Petitioner told her he fell on the ice walking up the hill from the boathouse. After work, they dropped off his truck and went to the emergency room. She testified that he got out of his truck and got into her car. He did not slip and fall on the ice on their driveway. She drove him to the emergency room.

Petitioner was seen in the emergency room at Mercy Harvard Hospital on January 21, 2016 (PX 1). He arrived at 4:57 PM (PX 1, p 15). His chief complaint was right shoulder pain post fall. The record notes patient reported that he slipped on ice in his driveway just prior to arrival to the emergency department (PX 1, p 17). Petitioner testified he told them he fell in the driveway. X-rays were negative for fracture or dislocation. Petitioner was released in a sling and advised to see his primary care physician for an MRI and informed that he may have a rotator cuff injury (PX 1, p 19). Petitioner left the ER at 5:32 PM (PX 1, p 15). Petitioner testified he was discharged and called Mark Walker at 5:29 PM. He testified he told Mr. Walker that he had to see his primary care doctor.

Petitioner's cell phone records (PX 7) confirm the calls with Mr. Walker on January 21, 2016. Petitioner also called his wife's office at 3:25 PM. He made a call originating from Poplar Grove at 4:16 PM. He made calls to his wife's cell phone at 4:27 PM and 4:31 PM, just before and after the 4:29 PM call to Mr. Walker, both originating in Poplar Grove.

Petitioner saw his family doctor Dr. Lesser on January 22, 2016 (PX 2, p 22-25). The history recorded is patient was in his driveway yesterday, slipped on ice and hurt his right shoulder. An MRI was ordered and Petitioner was to see Dr. Izquierdo if not 100%. The MRI performed January 26, 2016 found impingement and a complete tear of the supraspinatus and partial tear of the bursal surface of the infraspinatus (PX 2, p 21).

Petitioner testified that he called to make an appointment on January 22, 2016. The Telephone Encounter includes a history that Petitioner slipped and fell on ice in his driveway (PX 3, p 34). He saw Dr. Izquierdo on January 28, 2016 providing the same history and advancing complaints of pain in the right shoulder. After examination and review of the MRI, Dr. Izquierdo's assessment was unspecified rotator cuff tear or rupture of right shoulder, not specified as traumatic. He recommended arthroscopic surgery (PX 3, p 30-32). Petitioner testified he did not return to work for Respondent after the January 28, 2016 visit. He had a conversation with Mr. Walker on January 31, 2016. Petitioner testified that Mr. Walker said "Darn it, Tim, you fell on ice. I could understand if you fell off a ladder." Petitioner testified that Mr. Walker told him he should have told him earlier. Mr. Walker testified he did not recall a conversation on January 31, 2016. The phone records (PX 7 and RX 5) confirm calls made on that date.

Petitioner's Workers' Compensation claim was denied on February 17, 2016. Petitioner decided to proceed through his group insurance (PX 3, p 27). Petitioner presented a claim for benefits through the Carpenters Welfare Fund on February 23, 2016 (PX 10). Petitioner stated that the injury occurred when he fell on ice at job site. He stated it occurred towards the end of the workday when he went to lock up building where materials were stored. Dr. Izquierdo completed the second page of the form with the injury described as slipped and fell on ice in his driveway. In response to the question, "is the condition due to injury arising out of the patient's employment," he responded "No."

Petitioner had a pre-operative clearance appointment with Dr. Lesser on March 8, 2016 (PX 2, p 10-15). He underwent surgery on March 18, 2016. Dr. Izquierdo performed right shoulder arthroscopic repair of a large full thickness rotator cuff tear involving tears of the subscapularis, supraspinatus and infraspinatus tendons, an arthroscopic biceps tenodesis and subacromial decompression with anterior acromioplasty. The postoperative diagnosis was a right shoulder large full-thickness rotator cuff tear involving 3 tendons, right shoulder subacromial impingement and right shoulder bicipital tendinosis with partial-thickness tearing and instability (PX 3, p 38-40).

Petitioner followed up with Dr. Izquierdo post operatively on March 21, 2016. He was not to perform any lifting more than 1-2 pounds for 8 weeks to protect the integrity of the biceps tenodesis (PX 3, p 19). Petitioner began physical therapy at Poplar Grove Physical Therapy on April 8, 2016. The progress notes indicate a date of onset of 1/26/2016 and the description was that patient slipped and fell onto his right elbow at his boss's house. He stated that he was building a closet underneath the stairs at his boss's house. The materials he was using were stored in the boat house. He was walking to the boat house to lock it and keep the materials safe when he slipped on ice and fell onto his right elbow. The onset was due to an on-the-job injury (PX 4).

On April 21, 2016, Dr. Izquierdo advised Petitioner not to lift more than 1-2 pounds for the next 8 weeks (PX 3, p 15-16). He saw Dr. Izquierdo on May 19, 2016, June 16, 2016 and July 12, 2016 (PX 3). Petitioner continued in physical therapy through his discharge on August 4, 2016 (PX 4). On August 9, 2016, Dr. Izquierdo released him to full duty work. He was to gradually progress activities and work on stretching and strengthening of the right shoulder through his home exercise program (PX 3, p 2). On September 12, 2016, Petitioner complained of pain and popping in the right shoulder. His pain with activity was 3/10, there was no numbness or tingling or dislocation. Dr. Izquierdo opined that he should continue his home exercise program and use anti-inflammatories as necessary for discomfort. He placed the Petitioner at maximum medical improvement (PX 3, p 4).

Petitioner submitted bills from Poplar Grove Physical Therapy (PX 6) and Family Medicine for McHenry (PX 8). These bills indicate the patient's condition is not related to employment.

Petitioner testified that, upon his release to return to work, he did not contact the Respondent because it was his impression that once you are hurt, "you're going to get the crap jobs." Instead of causing friction and aggravation, he looked for employment elsewhere. Petitioner accepted a job as a carpenter at Maman Corporation at Union scale of $45.35 per hour around September 28, 2016. He testified that he is right-hand dominant. When he uses his right shoulder during work up high using a screw gun, he does not have the pressure like he used to. His right shoulder hurts him when he wakes up in the morning. He feels a pricking sensation in his shoulder and he has to move it around before it goes away. His right shoulder gets very sore after work from using it all day. He takes ibuprofen but no prescription medication.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. Included within that burden, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of his employment.

Petitioner testified that at about 1:30 PM on January 21, 2016, while working for Respondent at Mark Walker's residence in Delavan, Wisconsin, he was going to lock the boat house where the materials were stored, and when he went to retrieve a tool from his truck that was parked in the driveway; he slipped and fell on ice. Petitioner testified that he told his fellow employee Jose Sandoval that he could not raise his arm while working on a piece of drywall on the ceiling. He testified he told Jose that he fell on the ice. Petitioner testified he spoke with Mark Walker at 2:56 PM. Petitioner never mentioned anything about the slip and fall. Petitioner testified that after he left the job site, he drove to his wife's office in Poplar Grove. He testified that he arrived at his wife's office at approximately 4 PM. The drive from Delavan, WI to Poplar Grove, IL took 45 minutes to an hour. He testified that he called Mark Walker at 4:29 PM and told him that he slipped and fell on the ice at Walker's residence and hurt his shoulder and was going to get it checked out because of the intensity of the pain. He testified from there he went to the emergency room at Mercy Harvard Hospital.

It is undisputed that Petitioner did not report any injury to Mr. Walker in the 2:56 PM telephone conference, and thereafter, did so at 4:29 PM. But the remainder of Petitioner's testimony, including the details of his accident, work day and activities thereafter, has many inconsistencies and is contradictory with the much of the remainder of the evidence presented.

The Mercy Harvard Hospital emergency room history, taken at about 5:00 PM on the day of the injury, states that Petitioner slipped on ice in his driveway (not the work site) just prior to arrival. The insurance information lists Blue Cross, not Workers' Compensation. The medical history of the fall in his driveway in repeated in the records of Dr. Lessor and Dr. Izquierdo. Even on the Union benefit application filed in February, 2016, Dr. Izquierdo continues to state that the fall occurred when Petitioner slipped and fell on ice in his driveway. In response to the question, "is the condition due to injury arising out of the patient's employment," he responded "No." Dr. Lessor and Poplar Grove Physical Therapy submitted billing forms listing the charges as unrelated to Petitioner employment. Petitioner's explanation of the initial emergency room mistake is unpersuasive since he was already aware of Mr. Walker's questioning his story before he went to the emergency room and he not only did not make sure the history was correct, but did not correct this in the following multiple visits with other providers. His testimony of his opinions of the negative consequences of pursuing Workers' Compensation are similarly unpersuasive given that he had already reported the injury by 4:29 PM and his insistence of claiming an on the job injury in February, 2016 on the Union welfare fund application.

Even in the evidence including the work related history, the exact details of the fall vary. Petitioner testified that he fell on the driveway before going to the boathouse to lock it up. Mrs. Cassens testified that he told her he fell on the ice walking up the hill from the boathouse. On the Union benefit form, Petitioner stated that the injury occurred when he fell on ice at job site. He stated it occurred towards the end of the workday when he went to lock up building where materials were stored. The physical therapy records state that he was walking

to the boat house to lock it when he slipped on ice and fell onto his right elbow. The only mention of a driveway is in his testimony at trial, and the medical records noting he fell in his driveway.

Petitioner's testimony and timeline are also contradicted by other evidence. Petitioner testified that the injury occurred at 1:30 PM and he was in such pain that he needed help to complete his work duties. Yet Jose Sandoval testified that he was unaware of any injury to Petitioner and did not need to assist him in completing the drywall. He also contradicts Petitioner's testimony that he was told of the accident before the end of the workday. Petitioner's explanation for not mentioning the accident at 2:56 is not persuasive if he was in fact having as much pain as he testified to.

Petitioner and his witnesses testified to a general timeline of his activities between leaving work in Delavan and ultimately arriving in the Mercy Harvard Hospital emergency room, but some inconsistencies are not explained. The telephone records do document his call to his wife's office at 3:25 from Lake Geneva, although Arbitrator notes that Lake Geneva is not on a direct route to Poplar Grove from Delavan. Petitioner did not testify to his route. He testified that he arrived at the H & R Block office at about 4:00 PM. His testimony and that of Mrs. Cassens imply that they were together until after he called Mr. Walker at 4:29 PM and they left to drop off his truck and go to the hospital. Yet the Petitioner's telephone records show that he and Mrs. Cassens exchanged cell phone calls at that time without an explanation of the need if they were both still in the office. And the 4:31 PM call indicates that Mrs. Cassens was in Woodstock.

It is the Commission's function to judge the credibility of the witnesses, determine the weight to be given their testimony, and resolve conflicting medical evidence. *Tower Automotive v. Illinois Workers' Compensation Comm'n, 407 Ill. App. 3d 427, 435, 943 N.E.2d 153, 161, 347 Ill. Dec. 863 (2011)*. The weight given to the evidence is determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the witness and the nature of the case and its facts. While any one of the discrepancies in the evidence may have a plausible explanation, the sheer volume of the Petitioner's varied and inconsistent histories of the January 21, 2016 incident coupled with the contradictory testimony and documents undermine his claim that he suffered accidental injuries arising out of and in the course of his employment,

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent on January 21, 2016.

In support of the Arbitrator's decision with respect to (F) Causal Connection, (J) Medical, (K) Temporary Compensation, (L) Nature and Extent, and (M) Penalties, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Accident, the remaining issues of Causal Connection, Medical, Temporary Compensation, Nature and Extent, and Penalties are moot. Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Donna Miller,

Petitioner,

vs. NO: 17WC 0238

Berwyn North School District #98,

18IWCC0409

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 accident and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 29, 2017, is hereby affirmed and adopted.

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

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

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

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

DATED: JUN 29 2018

o062618
SM/jrc
052

Stephen Mathis

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MILLER, DONNA
Employee/Petitioner

Case# **17WC000238**

NORTH BERWYN SCHOOL DISTRICT #98
Employer/Respondent

18IWCC0409

On 8/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

1120 BRADY CONNOLLY & MASUDA PC
NICHOLAS A RUBINO
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

Donna Miller
Employee/Petitioner

v.

Berwyn North School District #98
Employer/Respondent

Case # 17 WC 0238

Consolidated cases:

18IWCC0409

An *Application for Adjustment 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 **June 19, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **November 30, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

On the date of accident, Petitioner was **48** years of age, *married* with **2** dependent children.

ORDER

Petitioner has proven by a preponderance of the evidence that her accident arose out of and in the course of her employment. By agreement of the parties, all other unaddressed issues are reserved for a later proceeding.

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

8-28-17
Date

ICArbDec19(b)

AUG 29 2017

FINDINGS OF FACT

Petitioner, Donna Miller, was working for Respondent as a fourth grade school teacher on November 30, 2016. (T 11, 18.) Petitioner was going to pick up her students from recess, which requires walking down a staircase. (T 12.) Petitioner's lunch break was over and she was on the clock. (T 12, 38.) Petitioner was carrying a lunch bag on her wrist in her right hand, and had a cup of soda in her left hand. (T 12.) The bag had a zipper, but was unzipped; it was holding Petitioner's glasses, her phone, Tupperware containers, and mini candy bars. (T 82.) The soda was in a Solo cup. (T 47.) The bag and the soda were both from her lunch; there was a teacher's luncheon, so food and drinks had been provided to teachers in the teacher's lounge. (T 14, 47.)

As Petitioner reached the top landing of the stairwell; she prepared to walk down the right side of the stairs. (T 12, 16.) At this moment, a student from a co-teacher's class was walking up the stairs. (T 12, 23.) She said, "Hi, Ms. Miller." (T 12.) Petitioner turned and looked over her left shoulder to say hello, at which point she stepped and fell down the stairs. (T 12-13.) The stairs had a handrail on either side, and eight to nine steps from the top landing to the first landing. (T 15.) Petitioner was unable to grab a railing as she fell; she bounced down the stairs and landed on the first landing. (T 13.) As she fell, the things Petitioner was carrying went flying: the soda spilled all over the stairwell, the cup flew one way, her phone flew a different way, her glasses flew another, as well as the lunch bag. (T 82.)

The student came to Petitioner's aid and asked if she should get help. (T 27.) The student then ran and retrieved a teacher from her classroom, Ashley Hines. (T 27-28.) Subsequently, a second teacher who was coming up from the bottom of the stairs arrived. (T 27.) Petitioner testified that she believed the teacher who came up from the bottom to her aid picked up her lunch bag, because it was returned to her as she was sitting in the nurse's office. (T 82-83.) Petitioner gave a statement to the school nurse, Julie. (T 28-29.)

Subsequently, Petitioner's son came and picked her up, and she sought treatment at Adventist LaGrange Hospital. (T 30, 44.)

At the arbitration hearing, Petitioner testified that she had a 35-minute lunch break each day. (T 16.) Petitioner's lunch period ended at 12:30 PM. (T 19.) Petitioner testified that every day, every teacher must go down the stairwell and retrieve their students from the recess doors as part of their normal job duties. (T 12.) Petitioner did so each day after her lunch. (T 16-17.) There are ladies watching the children on the playground, and the ladies need to be free to go watch the next group of students, so it's important for the teachers to pick up their students on time. (T 19.) The recess ladies ring the bell to line up the students at 12:30 PM, and Petitioner would then have three or four minutes to get down there. (T 19-20.)

Petitioner testified that the hallway would become very crowded with students at this time of day. (T 22.) Petitioner estimated that it would take her one minute to traverse the hallway from the teacher's lounge to the top of the stairs. (T 20-23.) It was typical for Petitioner to see students in the back stairwell; most days, going up and down the stairs during lunch or at another time, Petitioner would probably see students. (T 48.) Petitioner would see fourth grade students coming back from lunch or going to lunch every day. (T 49.)

Petitioner testified that she always took the back staircase, which is the staircase she was told to take. (T 45.) There is a front staircase as well that is open for use on the other side of the building from the teacher's lounge and would be filled with fifth graders going down to lunch at this time of day. She also said it would not make sense for Petitioner to use the front stairwell to retrieve the fourth grade students from recess. (T 46, 49.)

Ashley Hines, a coworker of the Petitioner's worked for Respondent as a special education teacher. (T 53-54.) Hines testified that in addition to the front and back stairwells, there is also an auditorium stairwell that goes to the second floor. (T 56.) On November 30, 2016, she was working for Respondent and heading to the back stairwell to pick up her students from recess after her 35-minute lunch period between 11:55 AM and 12:30 PM. (T 54-55.) Hines testified that it would take her approximately a minute and a half to walk from the teacher's lounge to the back stairwell on any given day. (T 60.)

Hines testified that after she picked up her students from recess, she returned to the back stairwell and observed Petitioner laying face-down, her torso laying on the first landing and her legs still on the stairs above. (T 61.) Hines did not see Petitioner fall, and could not testify as to what happened prior to discovering her on the stairwell. (T 64.) Hines did not remember whether she observed a purse or lunch bag on the stairwell. (T 62, 64-65.) Hines testified that she did not see defects in the stairwell. (T 63.)

Jessica Hartless was principal of Havlicek School on November 30, 2016. (T 67.) She testified that she did not observe Petitioner's accident, and that she did not see or hear anything in the seconds prior to the accident. (T 76-77.) Hartless testified that she did not see Petitioner at the top of the stairs before the accident or as she was falling down the stairs; Hartless testified that she did not know what items Petitioner had with her when she was at the top of the stairs. (T 78.) Hartless did not arrive at the scene until after the nurse evaluated Petitioner and she was brought down to the first floor. (T 75-76.) Hartless testified that when she arrived at the scene, a staff member was holding Petitioner's cell phone and glasses, and that Petitioner was not holding anything at the time. (T 79-80.)

Respondent submitted two pages of a School Employees Loss Fund report: one an unsigned document entitled "Employee's Report of Injury," and the second a "Supervisor's Investigation Report" signed "Jessica Hartless." (RX2.) Petitioner testified that Nurse Julie filled out the accident report, and that "I was never privy to what she wrote on the accident form." (T 41-42.) Principal Hartless testified that the first portion of the report was "filled out by school district personnel. We filled that out together, and then I contacted witnesses based on the information I was given at the initial time the accident happened to give them their necessary paperwork." (T 68.) Hartless later testified that the Employee's Injury Report was "turned in not by me but by the employee, themselves." (T 74.)

CONCLUSIONS OF LAW

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

The Arbitrator incorporates the findings of facts as though fully set forth herein. At trial, the sole issue in dispute, by stipulation, is whether Petitioner's accident arose out of and in the course of her employment with Respondent. For the foregoing reasons, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that her accidental injuries arose out of and in the course of her employment with Respondent. The Arbitrator also finds Petitioner's testimony credible, reliable and otherwise unrebutted by Ashley Hines and Jessica Hartless. The Arbitrator finds the testimonies of Hines and Hartless generally credible as to the history of the incident as they recollected it.

"An employee's injury is compensable under the Act only if it arises out of and in the course of the employment." *Univ. of Ill. v. Indus. Comm'n,* 365 Ill. App. 3d 906, 910, 851 N.E.2d 72, 77 (1st Dist. 2006). There is no issue here concerning whether the claimant's injuries were sustained in the course of her employment because the accident happened on the employer's premises during her regular work hours and the evidence established she was leaving a teacher's meeting and on her way to retrieve her students. "Injuries

sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, are generally deemed to have been received in the course of the employment." *Metropolitan Water Reclamation District of Greater Chicago v. Ill. Workers' Comp. Comm'n,* 407 Ill. App. 3d 1010, 1013-14, 944 N.E.2d 800(1st Dist. 2011). The "arising out of" component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. Courts have recognized three general types of risks to which an employee may be exposed: (1) risks that are distinctly associated with the employment; (2) risks that are personal to the employee; and (3) neutral risks that do not have any particular employment or personal characteristics.

In the instant case, Petitioner's injuries occurred when she fell down a flight of stairs after turning back to talk to a student. Falling down a flight of stairs does not qualify as a risk distinctly associated with Petitioner's employment as a teacher. However, the risk of falling down a flight of stairs is also not personal to this Petitioner. See *Ill. Inst. Of Tech. Research Inst.,* 314 Ill. App. 3d 149, 162-63, 731 N.E.2d 795 (1st Dist. 2000). Rather, it is a neutral risk, and whether Petitioner is entitled to compensation depends on whether she was exposed to the risk of injury to a greater extent than the general public. Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public.

In *Blevins v. St. John's Hospital*, the claimant argued her accident arose out of her employment when she fell down a flight of stairs. 210 Ill. Wrk. Comp. LEXIS 206 (2010). The Commission noted that the facts demonstrated the stairway was not normally used by the public and that there may have been traction slip at the edge of the step slightly raised. In finding compensability, the Commission also noted it reached its decision based on the foregoing factors rather than the Arbitrator's stated reliance on the fact that the claimant was distracted by a co-worker when she turned back to speak to them and fell and on the fact that her view was partially blocked by the items she carried in her hands. The Commission further found that the claimant's risk of injury was increased due to her use of the stairs to travel within the employer's premises for work related meetings. In the instant case, Petitioner used this particular staircase frequently to retrieve her students and similarly lost her footing when she turned around to speak to a student. Thus, Petitioner's risk of injury was increased compared to the general public.

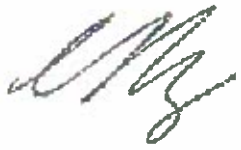
In *Knox County YMCA v. Indus. Comm'n*, the Commission found claimant's slip and fall down the stairs was compensable where her soft drink in one hand and purse in the other, both of which she would not have had absent a mandatory CPR class, increased her risk. 311 Ill. App. 3d 880 (3d Dist. 2000). The court noted that because claimant "fell while attending a mandatory CPR class," she was performing an act that she was instructed to perform by the employer. Further, although the stairs were well lit, there were no obvious defects and descending a staircase does not present a greater risk, the court emphasized the fact that the claimant was holding a drink and a purse in her hands, which she would not have had absent the mandatory CPR class. The instant case is analogous to *Knox County*. In this case, it is undisputed that Petitioner was carrying a lunch bag on her wrist in her right hand and had a cup of soda in her left hand, each containing food and or drink provided by Respondent as part of a teacher's luncheon provided by Respondent. Petitioner testified that she did not grab the railing as she was falling. Petitioner also testified that she was on her way to retrieve her students, who were finishing up recess. Petitioner is notified the students are ready to be picked up because a bell is rung and is given a few minutes leeway for the students picked up in order to watch the next set of students. Thus, the Arbitrator finds that Petitioner was under a time limit in terms of her traversing the stairs to retrieve her students. Petitioner's unrebutted testimony noted that the route she used was the back stairs and that she was told to use the back stairs. Ashley Hines' testimony supported these statements. Finally, Petitioner's testimony was that she was attending a teacher's luncheon and that the cup in her hand was

provided to her at the luncheon. Based on the foregoing and pursuant to *Knox*, it follows that Petitioner was subjected to an increased risk of injury compared to the general public.

In *Jackson v. Lincoln's Challenge*, the Commission denied compensation, finding that the claimant's fall down school stairs when his combat boot caught on a step did not arise out of any employment. The Commission noted that while the stairwell was not open to the public, there were no defects and no risk that otherwise increased the claimant's risk of injury. 16 IWCC 487, 2016 Ill. Wrk. Comp. LEXIS 363 (2016). The Arbitrator finds *Jackson* distinguishable. While a defect may be one way to establish an increased risk of injury from an otherwise neutral risk, in the Arbitrator's view, these lines of cases are not applicable because the basis for which compensation is being awarded here is not based upon any defect but rather Petitioner's increased risk of injury because she was distracted by a student talking to her, that she had items in her hands, some of which were related to the luncheon she was just leaving, that she took a specific route to retrieve her students and that she was otherwise under a time limit. See also *Haugh v. Marquette Bank*, 2016 IWCC 840, 2016 Ill. Wrk. Comp. LEXIS 558 (2016).

Finally, the Arbitrator notes that Petitioner's account at trial of how her injuries occurred were credible, forthright and otherwise consistent with her treatment records. For example, on the same date she fell, petitioner related to Family Medical Center of LaGrange and Adventist that she missed a step and fell down some stairs. She reported immediate shoulder pain, along with an onset of other symptoms to other body parts. Rx3, 6. She likewise reported to another treater that she missed the top step of the stairs and fell. Rx5. The report of injury similarly describes Petitioner falling down stairs. While some of the records do not mention missing a step, being distracted by a student, turning around to talk to a student, carrying items in either hand or going to retrieve students, the Arbitrator does not find these documents so inconsistent with Petitioner's trial testimony that compensation as to the issue of accident should be denied. The mechanism of injury is all consistently described as Petitioner falling down the stairs after being distracted and turning around to address a student. Whether she missed the step at the landing, the next step or the steps after she began falling is a distinction not entitled to much weight as it is clear she missed at least one step based upon the evidence presented. In addition, Ashley Hines similarly testified that she noticed certain items belonging to Petitioner were strewn about the stairs, further corroborating Petitioner's testimony that she had items in her hand. Again, while this fact did not make it into any particular medical record, Petitioner's testimony is otherwise unrebutted and remains credible.

Based on the foregoing and on the record as a whole, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that her accident arose out of and in the course of her employment.



Signature of Arbitrator

8-28-17
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)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
WILLIAMSON		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chad Mulholland,
Petitioner,

vs. NO: 15WC 14609

18IWCC0410

State of Illinois/Menard Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of 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 January 17, 2018, is hereby affirmed and adopted.

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

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

DATED: JUN 29 2018
062618
KWL/jrc
042

Kevin W. Lamborn

Stephen Mathis

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MULHOLLAND, CHAD
Employee/Petitioner

Case# **15WC014609**

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

18IWCC0410

On 1/17/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4852 FKCG
JASON COFFEY
PO BOX 191
CHESTER, IL 62233

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

JAN 17 2018

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

CHAD MULHOLLAND
Employee/Petitioner

v.

STATE OF ILLINOIS/MENARD CORRECTIONAL CENTER
Employer/Respondent

Case # 15 WC 14609

Consolidated cases: _____

18IWCC0410

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **July 12, 2017**. By stipulation, the parties agree:

On the date of accident, **April 19, 2015**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**58,528.60**, and the average weekly wage was $**1,125.55**.

At the time of injury, Petitioner was **27** years of age, ***single*** with **2** dependent children.

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

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

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 $675.33/week for a further period of 5 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused 1% loss of use of the person as a whole.

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

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

Signature of Arbitrator

January 14, 2018
Date

JAN 17 2018

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

18IWCC0410

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

CHAD MULHOLLAND
Employee/Petitioner

v.

Case #: 15 WC 14609

STATE OF ILLINOIS/MENARD CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

The parties stipulated that on April 19, 2015, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent. The parties further stipulated that all medical benefits had been or would be paid by Respondent. The parties stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability.

On the date of accident, Petitioner was 27 years old, single, and had two dependent children. He was employed as a Correctional Officer at Respondent's Menard Correctional Center, a position he had held for approximately seven years. On that date, he and another officer were supervising an inmate at Chester Memorial Hospital. The inmate was to receive an IV and was scared of needles. He began to struggle with the nurse administering the IV and Petitioner attempted to restrain him. The nurse attempted to insert the tubing of the IV into the inmate several times without success and at one point pulled the tubing out, resulting in the needle coming out and puncturing Petitioner in the right thumb.

Due to the potential exposure to various diseases, Petitioner was taken to the emergency room at the same hospital and was treated. He notified his employer of the injury. Petitioner underwent a series of injections at the hospital and blood was drawn. He was later released and ordered to follow up with his primary care physician.

Petitioner's primary care physician, Dr. Mark Preuss, ordered him to undergo a series of blood tests at intervals of three, six, nine, and twelve months. Petitioner testified he underwent the testing as ordered and that all tests came back negative for HIV and Hepatitis.

Petitioner testified that he began seeing a counselor and psychologist for emotional/psychological issues he was having while undergoing the series of blood tests. Petitioner testified he was having severe anxiety and depression because of his fears that he had an incurable disease. He was 27 years old at the time of the incident and had two children to care

for. He was prescribed Prozac and Celexa during this period. Petitioner testified that he did not feel either medication worked, so he began using alcohol very heavily. When he began having issues with alcohol, he sought further counseling.

Petitioner testified that he has returned to work and feels he can perform his job duties. However, he received "blemishes" on his work record for attendance issues and drinking and driving shortly after the work incident, which he now associates with his emotional/psychological symptoms following the work injury.

On cross-examination, Petitioner confirmed that all blood testing was negative. He acknowledged that he was seen only two or three times by the counselor. He further acknowledged that he had been to a counselor in the past for issues relating to his child custody case and that he had been treated for anxiety prior to the work injury.

Medical records entered into evidence at arbitration indicate that Petitioner was seen at the emergency room on April 19, 2015, presenting for a needle stick that had occurred. He was encouraged to immediately wash his hand at the sink with soap and water. He was given two tetanus diphtheria toxoid injections. Upon completion of treatment, Petitioner desired to go back to work with a referral to his primary care physician. PX2.

On April 21, 2015, Petitioner presented to Dr. Mark Preuss, his primary care physician. He reported a consistent history of the accident and treatment in the ER and advised that the lab results were still pending. He reported he was "concerned with a false negative reading on the HIV panel and would like to have serial labs drawn for reassurance". Petitioner was ordered to undergo repeat HIV, Hepatitis C, and Hepatitis B testing in three months and again in six months for reevaluation. The HIV screen was negative on April 19, 2015. The HIV, Hep A, Hep B, and Hep C screen was negative on July 24, 2015. The HIV and Hep C screen was negative on October 22, 2015. The HIV and Hep C screen was negative on April 27, 2016. PX3.

Petitioner sought counseling treatment on December 8, 2015, with Living Waters Counseling, through Respondent's Employee Assistance Program. He reported he was experiencing a wide range of emotions since he had been exposed to an inmate's blood in April of that year. He voiced feelings of what he felt was a "death sentence" for him. He noted he was the butt of jokes by his co-workers who knew about his situation. He reported he never drank much alcohol until recently and had also recently been in a bar fight. He expressed he was having a lot of anxious thoughts about the possibility of having a life-threatening illness. Petitioner followed up with his counselor on January 5 and January 26, 2016. He described feelings of anger toward the inmate who he was supervising at the time of the injury. PX4.

On August 23, 2016, Petitioner began treating with Southern Illinois Psychiatry. He reported a long history of anxiety symptoms, which his primary physician was treating. He reported having an anxiety disorder and it was noted the onset was "as long as patient can remember". Petitioner followed up on September 20, 2016, January 27, 2017, and April 18, 2017. Although Petitioner was dealing with certain psychological and emotional issues during that time, none of the records mention the work injury. PX6.

CONCLUSIONS OF LAW

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

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

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Correctional Officer at the time of the accident and was able to return to work in that capacity without any restrictions or limitations as a result of said injury. The Arbitrator places significant weight on the fact that Petitioner returned to work without restrictions and thus places significant weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 27 years old at the time of the injury. Although this is a young age, the evidence shows his condition has resolved. The Arbitrator gives little weight to this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner returned to his prior position full duty with no change in pay. There was no evidence that his future earning capacity has been or will be impacted as a result of this injury. As such, the Arbitrator gives no weight to this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes that Petitioner was not exposed to HIV or Hepatitis based on the blood testing, but did suffer from emotional symptoms due to the potential exposure. The Arbitrator further notes, however, that Petitioner had a long-standing history of anxiety issues and had been on medication for same prior to this event. He attended three counseling sessions with Living Waters Counseling, ending on January 26, 2016, which can be directly attributed to this event. However, records from Southern Illinois Psychiatry make no mention of the work event whatsoever. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 1% loss of use of the person as a whole (5 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $1,125.55. The Arbitrator finds his permanent partial disability rate is $675.33.

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

Alan Housner,
Petitioner,
vs.

NO: 15WC 31127

Hinsdale Township H.S. District 86,
Respondent.

18IWCC0411

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 12, 2017, is hereby affirmed and adopted.

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

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

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

DATED: JUN 29 2018
o062618
SM/jrc
052

Steven Mathis

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOUSNER, ALAN
Employee/Petitioner

Case# **15WC031127**

HINSDALE TOWNSHIP H S DISTRICT 86
Employer/Respondent

18IWCC0411

On 6/12/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.07% 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:

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

1120 BRADY CONNOLLY & MASUDA PC
MATTHEW P SHERIFF
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

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

Alan Housner
Employee/Petitioner

v.

Hinsdale Township H.S. District 86
Employer/Respondent

Case # 15 WC 31127

Consolidated cases: _____

18IWCC0411

An *Application for Adjustment 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 **3/22/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/26/15**, 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 **$106,219.88**; the average weekly wage was **$2,042.69**.

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

Respondent shall be given a credit of **$22,372.26** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$22,372.26**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,361.79/week for 16 3/7 weeks, commencing 10/23/15 through 2/14/16, as provided in Section 8(b) of the Act.

Petitioner sustained permanent partial disability of 17% loss of a person as a whole. For the Arbitrator's analysis of the factors pursuant to Section 8.1(b) of the Act, see the attached Addendum.

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

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

Susan C. Mizgata

Signature of Arbitrator

6-9-17
Date

JUN 12 2017

ICArbDec p 2

ILLINOIS WORKERS' COMPENSATION COMMISSION

ALAN HOUSNER,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case: 15 WC 31127
	)	
HINSDALE TOWNSHIP H.S. DISTRICT 86	)	
	)	
Employer/Respondent.	)	**18IWCC0411**

ADDENDUM TO THE DECISION OF THE ARBITRATOR

This matter proceeded to hearing on March 22, 2017 in Wheaton, Illinois. (Arb. 1). The only issues in dispute are causal connection and the nature and extent of Petitioner's injury. (Id.).

Petitioner, an employee for the Respondent for 38 years, was working as a physical education/drivers education teacher/wrestling and track coach on May 26, 2015. On that day, he was disassembling a volleyball net. As he attempted to pull one of the polls out of the ground, he felt pain in his left shoulder and bicep.

On May 28, 2015, Petitioner sought treatment at Concentra where he complained of left arm pain. Popeye deformity was noted. Petitioner was restricted from use of the left arm, an MRI was ordered and he was referred for orthopedic consult. (PX. 2).

On June 3, 2015, Petitioner presented to Dr. Lawrence Lieber who noted a history of lifting up a 75 lb. volleyball stand when he felt a pop and pain in his left shoulder.
Dr. Lieber noted a recent MRI showed a left rotator cuff tear, rupture in the long head of the biceps and arthritis in the AC joint. (PX. 1). Petitioner's arm was placed in a sling. Petitioner followed up with the doctor one week later, at which time, physical therapy was ordered. (Id.).

Following conservative treatment, on August 10, 2015, Dr. Lieber recommended surgical intervention.

At the request of respondent, Dr. Verma conducted a Section 12 examination on October 7, 2015, at which time, he noted a left proximal biceps rupture with rotator cuff tear which was causally related to the May 26, 2015 work accident.

On October 23, 2015, Dr. Lieber performed arthroscopy, subacromial decompression, Mumford procedure, mini open repair of the rotator cuff and left shoulder. During surgery, Dr. Lieber noted a "through and through rotator cuff tear along with a ruptured biceps tendon".

As of June 2, 2016, Petitioner exhibited restricted range of motion due to stiffness. Dr. Lieber released Petitioner from care and advised him to continue a home exercise program and strengthening.
Petitioner testified that he continues to have difficulties with the shoulder and is limited from simple things like hanging a shower curtain. He has been unable to resume coaching wrestling as he cannot get down on the mat. He is unable to golf. He retired in May 2016 and continues to coach track.

CONCLUSIONS OF LAW

Causal Connection

Following a traumatic injury which caused a biceps tendon rupture and rotator cuff tear, Petitioner underwent arthroscopic surgical repair. Respondent's Section 12 physician, Dr. Verma opined that Petitioner's injuries were causally related to the accident at issue.

The Arbitrator found Petitioner presented as an honest, credible witness at the hearing.

Based on a careful consideration of the evidence contained in the record, including the treating medical records, the opinions of Dr. Verma and the testimony of Petitioner, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the work-related accident on May 26, 2015.

Nature & Extent of the Injury

The Arbitrator has considered the following factors set forth in Section 8.1(b) of the Act:

With regard to subsection (i) of §8.1b(b), Dr. Verma examined Petitioner on January 4, 2017, noting difficulty with above shoulder work and weakness. Based on his ongoing, residual left shoulder disability and functional loss including arm elevation, Dr. Verma issued a 7% upper extremity impairment rating. 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 Arbitrator therefore gives moderate weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a physical education/drivers education teacher as well as a wrestling and track coach on May 26, 2015. Given the physically active nature of Petitioner's occupation, the Arbitrator gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes Petitioner's date of birth is November 30, 1954. The Arbitrator gives greater weight to this factor as Petitioner's age is somewhat advanced yet he has many years left in which he will deal with the permanent physical impairments he sustained from the accident at issue.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner retired in May of 2016 as a full time employee although he continues to coach track. Given his testimony that he can no longer coach wrestling due to his physical impairment, the Arbitrator gives some consideration 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 following:

- The MRI taken soon after Petitioner's accident showed a left rotator cuff tear, a rupture in the long head of the biceps and arthritis in the AC joint.

- On October 23, 2015, Dr. Lieber performed arthroscopy, subacromial decompression, Mumford procedure, mini open repair of the rotator cuff and left shoulder. During surgery, Dr. Lieber noted a "through and through rotator cuff tear along with a ruptured biceps tendon".

- As of June 2, 2016, Dr. Lieber noted restricted range of motion due to stiffness. Dr. Lieber released Petitioner from care and advised him to continue a home exercise program and strengthening.

- Dr. Verma re-examined Petitioner on January 4, 2017, noting difficulty with above shoulder work and weakness. Based on ongoing residual disability with regards to the shoulder based on functional loss including arm elevation.

Petitioner testified that he continues to have difficulties with the shoulder and is limited from simple things like hanging a shower curtain. He has been unable to resume coaching wrestling as he cannot get down on the floor.

Because the treating records corroborate Petitioner's testimony related to permanent disability, the Arbitrator 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 under Section 8(d)2, the Arbitrator awards 17% loss of a person as a whole.

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

David Evans,

Petitioner,

vs. NO: 16WC 1893

Cook County,

18IWCC0412

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, average weekly wage, prospective medical, 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 September 8, 2017, is hereby affirmed and adopted.

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

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

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

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

DATED:

o062618
SM/jrc
052

Stephen Mathis

Kevin W. Lamborn

Thomas J. Tyrrell

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

EVANS DAVID
Employee/Petitioner

Case# **16WC001893**

COOK COUNTY
Employer/Respondent

18IWCC0412

On 9/8/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN AND MACIARIELLO
GERALD F CONNOR
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

0132 STATES ATTORNEY OF COOK COUNTY
JEREMY SCHWARTZ
500 RICHARD J DALEY CENTER
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)

DAVID EVANS
Employee/Petitioner

v.

COOK COUNTY
Employer/Respondent

Case # 16 WC 1893

Consolidated cases: D/N/A

18IWCC0412

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **July 20, 2017 and August 10, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **12/16/15**, 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.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to strains of the left shoulder, left knee and lower back that stabilized, but did not fully resolve, as of Dr. Lieber's April 27, 2016 Section 12 examination.

For the reasons set forth in the attached decision, and based on Respondent's binding stipulation, the Arbitrator finds Petitioner's average weekly wage to be $1,304.00. Arb Exh 1.

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

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

Respondent shall be given a credit of **$55,761.31** for temporary total disability (RX 6) and $3,353.55 for the 3-6/7 weeks of full pay ($1304.20/week) paid from 12/17/15 – 01/12/16 (RX 3), but only at the temporary total disability rate of $869.47, for a total credit of $59,114.86.

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 $869.47/week for 18 6/7 weeks, commencing 12/17/15 through 4/27/16, as provided in Section 8(b) of the Act.

Respondent shall pay the following reasonable and necessary medical expenses, pursuant to the fee schedule: 1) AMCI, $6,956.00 in charges through Dr. Lieber's examination of April 27, 2016 (PX 4); and 2) Premium Healthcare Solutions, 1/29/16 (MRIs of left shoulder and left knee), $4,661.00 (PX 4). With respect to the claimed EQMD prescription expenses, the Arbitrator awards no expenses other than those ($124.94 and $2,570.81) already paid by Respondent, as shown on RX 5.

For the reasons set forth in the attached decision, the Arbitrator declines to award prospective care in the form of lumbar epidural steroid injections.

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

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

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

Molly C Mason

Signature of Arbitrator

9/8/17
Date

ICArbDec19(b)

SEP - 8 2017

David Evans v. Cook County Sheriff
16 WC 1893

18IWCC0412

Summary of Disputed Issues

The parties agree Petitioner sustained an accident on December 16, 2015, while working as a corrections officer for Respondent. The disputed issues include causal connection, average weekly wage, medical expenses, temporary total disability and prospective care, with Petitioner seeking lumbar epidural injections. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified he has worked as a corrections officer for Respondent for twelve years. His job involves maintaining custody and control of detainees. T. 7/20/17, p. 12.

Petitioner identified the documents in PX 5 as his W2 forms for the years 2014, 2015 and 2016. Petitioner testified he earned roughly $92,000 from Respondent during the year preceding his December 16, 2015 accident. T. 18. [Petitioner's 2015 W2 form reflects gross pay of $91,209.97 and reported wages of $82,847.29.] Petitioner initially testified he worked "mandatory overtime every day." He went on to state, however, he was "mandated every day three or four times a week." He could be written up and severely disciplined if he declined overtime. T. 18.

Petitioner testified he received $1738 biweekly during the period Respondent paid him temporary total disability benefits. T. 19. He believed he last received a temporary total disability check on February 20, 2017. T. 21. [RX 6, a print-out of indemnity payments made to Petitioner, reflects Respondent paid temporary total disability benefits at the biweekly rate of $1,738.66 from January 15, 2016 through March 24, 2017. RX 3 reflects Respondent paid Petitioner his regular salary between the accident and January 23, 2016.]

Petitioner testified he was injured at work on December 16, 2015, when a detainee assaulted him. The detainee, who was confined to a wheelchair, pulled one of the arms off his wheelchair and began using the arm to break windows. At his supervisor's direction, Petitioner started to remove the other arm from the detainee's wheelchair. The detainee resisted and began using his fists to strike Petitioner in the stomach. Petitioner testified that, at this point, he "folded" and the wheelchair "flipped" and struck his knee. T. 14.

Petitioner testified he injured his ribs, stomach, left knee, back and shoulder as a result of the assault. T. 14-15. He believed he injured his right shoulder. T. 15.

Petitioner testified he initially sought treatment at Franciscan Physician Network. T. 15.

Records in PX 1 reflect Petitioner saw Dr. Kraff at Hammond Clinic Urgent Care on December 16, 2015. Dr. Kraff recorded a history of the work event, indicating Petitioner reported being punched in the left ribs by an inmate and falling onto a wheelchair, injuring his left knee, earlier that day. He also noted that Petitioner had undergone a colonoscopy in August 2015 and was seeing Dr. Chughtai for gastrointestinal bleeding.

On examination, Dr. Kraff noted tenderness of the left lateral ribs, a full range of left hip motion, some left knee pain and swelling and a small laceration on the left patella. He noted "no right leg injury and no arm or shoulder injury." He ordered X-rays of the chest and left ribs, left knee and left tibia/fibula. He recommended that Petitioner "limit work until December and [follow up with] company doctor."

On December 30, 2015, Petitioner began a course of treatment at AMCI – South Holland Medical Center. Petitioner saw Dr. Hooten, a chiropractor, on that date. Dr. Hooten recorded a history of the accident, indicating that, during a struggle with an inmate, Petitioner injured his left knee, left arm and low back.

Dr. Hooten did not note any right shoulder complaints. He indicated Petitioner complained of pain in his left shoulder, left chest area and low back. He described Petitioner as limping. On initial examination, he noted left shoulder tenderness, 5/5 strength and pain with supraspinatus press, tenderness along the seventh through twelfth ribs on the left side, abrasions along the left patella and proximal tibia, pain with left knee flexion, pain with posterior drawer testing of the left knee and tenderness/limited motion of the low back.

Dr. Hooten obtained X-rays of the left ribs, left knee and left tibia and fibula. He interpreted the films as showing no acute bony changes.

Dr. Hooten diagnosed a chest wall contusion, lumbar sprain, left shoulder sprain and left knee strain. He attributed these diagnoses to the accident. He took Petitioner off work, recommended X-rays of the left shoulder and lower back and referred Petitioner to Dr. Bilko, an orthopedist at the same facility. PX 2.

Petitioner saw Dr. Bilko the following day, December 31, 2015. The doctor noted a history of the accident and recorded complaints of left shoulder pain, left-sided chest pain, low back pain and left knee pain. He indicated that Petitioner did not feel capable of performing his regular correctional officer duties.

On initial orthopedic examination, Dr. Bilko noted mild tenderness to palpation on the lateral/axillary aspect of the rib cage, tenderness of the left shoulder and pain with abduction, tenderness over the lumbar spine, negative straight leg raising and tenderness over the left patella, patellar tendon and lower shin. He prescribed physical therapy and medication and continued to keep Petitioner off work. PX 2.

Petitioner began a course of therapy with Dr. Hooten thereafter.

Petitioner returned to Dr. Bilko on January 21, 2016. The doctor noted improvement of the left-sided chest pain but persistent low back, left knee and left shoulder complaints. He indicated that Petitioner still felt unable to return to work. His examination findings were essentially unchanged. He recommended continued therapy and medication. He directed Petitioner to remain off work. PX 2.

At Dr. Bilko's recommendation, Petitioner underwent MRI studies on January 29, 2016. The left knee MRI, performed without contrast, showed a small effusion and no evidence of ligament or meniscal tearing. The second page of the MRI report is missing. PX 3. The left shoulder MRI, performed without contrast, showed a subchondral bone cyst or contusion in the head of the humerus and a small

subchondral bone cyst or erosion in the head of the humerus at the posterior aspect along the insertion side of the infraspinatus tendon. The radiologist described the supraspinatus, infraspinatus and biceps tendons as normal. He also noted no labral abnormalities. PX 3.

On February 4, 2016, Dr. Bilko noted continued complaints relative to the left shoulder, low back and left knee. He indicated that Petitioner still felt unable to return to work. He described the MRI reports as "unremarkable." He recommended continued therapy and medication. PX 2.

Petitioner continued undergoing therapy and massage thereafter.

On February 25, 2016, Dr. Bilko noted somewhat improved left shoulder and left knee pain along with persistent low back complaints. He indicated Petitioner still felt unable to resume working. He recommended a lumbar spine MRI and continued therapy. He directed Petitioner to remain off work. PX 2.

On March 10, 2016, Dr. Bilko indicated that the lumbar spine MRI showed protrusions at L2-L3, L3-L4 and L4-L5. [No lumbar spine MRI report is in evidence.] He attributed the disc protrusions to the accident. He referred Petitioner to Dr. Agrawal, a physiatrist affiliated with the facility. He discharged Petitioner from his care and directed him to remain off work until cleared by Dr. Agrawal. PX 2.

Petitioner saw Dr. Olayemi, a family physician, on March 17, 2016, "for follow up of fatigue, weakness and anemia." The doctor noted that a previous work-up, including a colonoscopy, was negative. He also noted that Petitioner reported worsening abdominal pain and significant shortness of breath when attempting to run. He examined Petitioner and ordered blood work and an abdominal ultrasound. PX 1.

Petitioner saw Dr. Mbaoma, an oncologist, on March 23, 2016. He noted complaints of dizziness and severe pain after eating. He suspected iron deficiency anemia likely due to poor gastrointestinal absorption. He prescribed intravenous iron, B12 supplementation and a capsule endoscopy. PX 1.

Petitioner underwent a laparoscopic mesenteric lymph node biopsy with small bowel resection on April 12, 2016. PX 1.

Petitioner saw Dr. Agrawal at AMCI on April 26, 2016. The doctor noted Petitioner was still experiencing pain in his low back, left shoulder and left knee. He described Petitioner as "trying to avoid using his cane." [This is the first mention of any cane usage.] He indicated that Petitioner felt unable to resume working and was scheduled to undergo an IME the following day.

On lumbar spine examination, Dr. Agrawal noted pain with flexion and extension, tenderness along the left lumbar paraspinals, paraspinal spasm on the left, positive straight leg raising on the left at 45 degrees and diminished light touch sensation along the left thigh, shin and calf. On left shoulder examination, he noted pain with end range impingement testing.

Dr. Agrawal indicated that Petitioner remained a candidate for epidural injections but recommended Petitioner undergo a functional capacity evaluation in the interim, while awaiting authorization of the injections. He continued to keep Petitioner off work. PX 2.

At Respondent's request, Petitioner saw Dr. Lieber, an orthopedic surgeon, for purposes of a Section 12 examination on April 27, 2016. Petitioner testified this examination lasted less than five minutes. T. 16.

In his lengthy report (RX 4), Dr. Lieber recorded a history of the December 16, 2015 work accident and subsequent treatment. He described Petitioner as right-handed. He noted that Petitioner reported having strained his lower back a year earlier but described himself as pain free as of the accident. He also noted that Petitioner denied having any left shoulder or left knee problems before the accident.

Dr. Lieber noted that Petitioner complained of intermittent left shoulder pain and stiffness, left knee pain and swelling, especially with stair usage, and lower back pain with walking, bending and sitting. He indicated that Petitioner reported needing to use a cane due to his back discomfort. He described Petitioner as being unable to walk on his heels and toes.

Dr. Lieber examined Petitioner and reviewed records from Drs. Hooten and Bilko, along with the MRIs. He described the left shoulder MRI as showing AC joint arthropathy with associated bone cystic formation. He interpreted the left knee MRI as showing "no evidence of any acute meniscal pathology or significant intra-articular abnormality." He interpreted the lumbar spine MRI as showing "no evidence of any acute disc herniation but evidence of degenerative lumbar disc disease at the L2-L3 and L4-L5 levels."

Dr. Lieber diagnosed degenerative lumbar disc disease, degenerative rotator cuff syndrome, AC joint arthritis and left knee pain. He found no causal relationship between Petitioner's symptoms and the accident. He saw no need for additional treatment. He indicated it did not appear that Petitioner required chiropractic care in connection with the work accident, stating that "physical therapy and appropriate medical care would have been adequate." He found Petitioner capable of resuming unrestricted duty. RX 4.

Petitioner also underwent a functional capacity evaluation on April 27, 2016. Dr. Hooten conducted this evaluation. He found Petitioner capable of light physical demand work. Citing the Dictionary of Occupational Titles, he described Petitioner's correctional officer position as a heavy physical demand job.

Petitioner underwent work conditioning with Dr. Hooten on May 10 and 17, 2016. PX 2.

On May 13, 2016, Dr. Mbaoma noted that Petitioner had just finished his first chemotherapy cycle and had "multiple vague complaints." PX 1.

Petitioner testified he last saw Dr. Agrawal on May 24, 2016. T. 16-17. On that date, the doctor noted ongoing complaints relative to the lower back, left shoulder and left knee. He indicated that Petitioner was having difficulty performing work conditioning and had "missed many sessions." He described Petitioner as having plateaued with therapy. He noted the previously recommended injections had not yet been authorized. He found Petitioner to be "at MMI at this time if more aggressive care is not provided." He described Petitioner as "disabled until authorized to proceed with lumbar spine interventions." PX 2.

On June 6, 2016, Dr. Mbaoma noted that Petitioner was tolerating chemotherapy. He directed Petitioner to continue chemotherapy and return to him in one month. PX 1.

Petitioner testified he would undergo the recommended injections if he had the opportunity. He has not had the injections because Respondent has not authorized them. T. 17.

On July 26, 2016, Petitioner saw Dr. Kampner at the Hammond Clinic. Dr. Kampner noted that Petitioner had "just had his 5th chemo session" with Dr. Mbaoma and was experiencing severe throat and neck pain.

On October 26, 2016, Dr. Mbaoma described Petitioner as "not doing well" and in a wheelchair. He indicated that Petitioner complained of numbness and pinprick sensations from his feet to his knees. He placed chemotherapy on hold "in view of the severe neuropathy" and referred Petitioner to a neurologist.

Petitioner underwent bilateral knee X-rays the same day. The films showed "minimal left knee patellar enthesophyte and no other significant degenerative changes."

Petitioner saw Dr. Abbas, a neurologist, on November 15, 2016. The doctor noted that Petitioner had been diagnosed with adenocarcinoma of the small bowel and had last undergone chemotherapy a month and a half earlier. He also noted that Petitioner had developed numbness of his feet and fingers during that month and a half period. He indicated that Petitioner was having difficulty walking barefoot and complained of a "shock like sensation" from his neck down his spine when trying to move his head. After examining Petitioner, he diagnosed "severe peripheral neuropathy, most likely secondary to chemotherapy" but also possibly due to B12 deficiency. He ordered B12 studies and a bilateral lower extremity EMG. He noted that Petitioner "refused Lyrica." PX 1.

On December 1, 2016, Dr. Mbaoma noted that Petitioner was still experiencing numbness and tingling in his hands and feet as well as weakness from the knees down and looseness of his nails. He indicated that a neurologist had recommended Lyrica but that Petitioner had declined this medication due to concern about side effects.

Dr. Mbaoma recommended physical therapy for the knee weakness along with a repeat CT scan and laboratory studies. He directed Petitioner to return in one month. PX 1.

Petitioner testified he has been off work since the December 16, 2015 accident. Dr. Agrawal recommended he remain off work while awaiting authorization of the injections. T. 20-21.

Under cross-examination, Petitioner denied working for any employers other than Respondent during the period he received temporary total disability benefits. T. 21. He also denied receiving gambling winnings during this period. He does not go to casinos on a regular basis. T. 22.

Petitioner testified the injections that have been recommended are for his lower back. He could not recall when he last received any shoulder-related treatment. He last underwent care for his knee on the last day he saw Dr. Agrawal. He believes he last saw this doctor in 2016. T. 25.

The parties agreed to continue the case to allow Respondent to produce evidence bearing on the issues of overtime earnings and benefit payments.

At the continued hearing of August 10, 2017, the parties agreed Petitioner remained off work.

Salomon Martinez testified on behalf of Respondent. Martinez testified he has worked for Respondent for 24 years. During the last five years, he has been a superintendent. As of December 2014, he was assigned to Division 1. In February 2015, he began overseeing Cermak Health, where Petitioner worked. He has knowledge concerning the overtime performed by Respondent employees who were based at Cermak Health. The union contract provides that certain of these employees will work overtime on an occasional basis. Voluntary overtime is offered on a daily, rotating basis. The rotation is based on seniority, with the most senior employees having priority. Employees are entitled to bid for voluntary overtime in divisions other than their own. Preference is given to employees in the division where the overtime is needed. Employees who bid on voluntary overtime in divisions other than their own are at the bottom of the list. Mandatory overtime, in contrast, is assigned first to the least senior officer. The assignments continue until the need for the overtime is met.

Martinez testified that Petitioner's seniority date is June 2005.

Martinez identified RX 1 as a group of "time tracker" reports showing Petitioner's dates and hours of employment, FMLA leave, overtime, etc. The first page of RX 1 covers the period December 14 through 27, 2014.

Martinez testified that various codes appear on the time tracker reports. "RDO" refers to a "regular day off." "FMLA" refers to paid floating holidays taken pursuant to the Family Medical Leave Act. "OT 8" refers to eight hours of overtime while "OT 4" refers to four hours of overtime. As of December 17, 2014, Petitioner was assigned to "CMK," or Cermak Health. Cermak Health is the hospital that provides treatment to inmates. The code "EO" refers to "external operations." The term "DO1" refers to Division 1.

Martinez testified that Petitioner's regular assignment was neither Division 1 nor external operations.

Martinez testified that some of the overtime shown in Petitioner's time tracker reports is not coded. He is unable to say where Petitioner performed this overtime.

Martinez testified that an officer who performs mandatory overtime during a particular two-week period is not eligible for such overtime in the next period, unless a "horrific" need arises. An officer might perform mandatory overtime three or four times per year. The chances of Petitioner having performed mandatory overtime other than at Cermak Health are not good. Typically, there were sufficient volunteers to meet overtime needs. Petitioner "could have" performed mandatory overtime at Cermak but not during successive pay periods.

Referencing RX 3, Martinez testified that Respondent paid Petitioner his regular salary on the date of the accident, December 16, 2015 and thereafter through January 23, 2016. Petitioner raised no objection to PX 3.

Under cross-examination, Martinez testified overtime is mandatory when needed. If, hypothetically, Petitioner worked overtime but never volunteered to do so, his overtime was mandatory. The "time tracker" reports do not indicate whether the overtime Petitioner performed was

voluntary or mandatory. Respondent's Department of Corrections employs about 2,700 individuals. Petitioner's rank within that number is not shown in the "time tracker" reports.

On redirect, Martinez opined, based on his experience, that an employee such as Petitioner, who has nine or ten years of seniority, would not often be mandated to work overtime. Typically, there are "abundant volunteers" to meet overtime needs. It would only be in the event of a major holiday or event that an officer with that amount of seniority would be mandated.

In response to a question posed by the Arbitrator, Martinez testified he could not recall any major event occurring during the year preceding Petitioner's accident that would have required Petitioner to work overtime.

Arbitrator's Credibility Assessment

Petitioner's account of his accident was detailed but not entirely supported by his medical records. He testified to injuring his shoulder but had difficulty recalling which shoulder was involved. He believed it was the right. The doctor who saw Petitioner on the date of the accident did not note any arm or shoulder complaints, although he did note tenderness in the left chest/ribs. It was not until two weeks later that Dr. Hooten noted a complaint of left shoulder pain.

Petitioner was not candid with the Arbitrator concerning the cancer-related care he began in March 2016. Some of this care overlapped with his accident-related treatment at AMCI, which ended on May 24, 2016. There is no indication that Petitioner informed the physicians at AMCI, to whom he complained of left knee and back pain as well as generalized weakness, of the fact he was undergoing chemotherapy. Nor is there any indication that Petitioner told his family physician and oncologist, who recorded more diffuse complaints of numbness and weakness in both legs, of his accident-related care.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed accident of December 16, 2015 and his claimed current conditions of ill-being?

The Arbitrator finds that Petitioner's undisputed work accident of December 16, 2015 resulted in soft tissue left shoulder, left knee and lower back strains which stabilized, but did not fully resolve, as of April 27, 2016, the date of Dr. Lieber's examination. In finding causation as to a left shoulder strain, the Arbitrator acknowledges that the physician who evaluated Petitioner on the day of the accident noted no arm or shoulder complaints. It was not until Dr. Hooten evaluated Petitioner two weeks later that any physician documented a left shoulder injury. Regardless, the Arbitrator finds it plausible that the assault described by Petitioner could have caused a left shoulder strain. There is no evidence suggesting Petitioner injured his left shoulder at some point between the accident and his first visit to Dr. Hooten.

What were Petitioner's earnings? What is Petitioner's average weekly wage?

Petitioner claims earnings of $91,209.87 and an average weekly wage of $1,741.93. Respondent stipulated to earnings of $67,808.00 and an average weekly wage of $1,304.00. Arb Exh 1.

The dispute centers on the nature of Petitioner's overtime. Petitioner initially testified he performed mandatory overtime "every day." He then indicated he was mandated three or four days per week. He testified he would have been subject to discipline if he had declined to work overtime. He did not, however, rebut superintendent Martinez's description of the seniority-based protocol Respondent followed in doling out overtime. Nor did he counter Martinez's opinion that it was unlikely he performed much mandatory overtime, given the abundance of volunteers.

In terms of documentary wage evidence, Petitioner offered only his W2 forms for the years 2014, 2015 and 2016. Those forms do not show how much of Petitioner's annual earnings consisted of overtime, let alone voluntary versus mandatory. Respondent's wage-related documents are considerably more detailed in that they reflect overtime as well as regular hours but they do not show which overtime hours, if any, were mandatory.

Under Illinois law, the claimant bears the burden of establishing his average weekly wage. Edward Don Co. v. Industrial Commission, 344 Ill.App.3d 643, 655 (2003). While Section 10 of the Act explicitly states that overtime is to be excluded in calculating a claimant's average weekly wage, the courts have held that overtime can be included, at the straight time rate, if there is evidence establishing that the claimant was required to work overtime as a condition of his employment, that he consistently worked a set number of overtime hours per week or the overtime hours he worked were part of his regular schedule. Freesen, Inc. v. Industrial Commission, 348 Ill.App.3d 1035, 1043 (4th Dist. 2004). In the instant case, Petitioner testified he was regularly required to work overtime but did not rebut Martinez's detailed explanation of how Respondent met its overtime needs. The Arbitrator finds credible Martinez's testimony that, for the most part, Respondent met those needs via volunteers. Petitioner performed 694 hours of overtime during the year preceding the accident, as evidenced by the "time tracker" reports in RX 1, but there is no way for the Arbitrator to determine how much, if any, of that overtime was mandatory. While Petitioner typically worked 8 hours of overtime on the days he worked overtime, that was not always the case, and there were some two-week-pay periods in the latter part of July and August 2015 during which he worked very little overtime. Moreover, there are no records in RX 1 concerning the periods June 14, 2015 through July 11, 2015 or July 26, 2015 through August 8, 2015. Petitioner did not testify to his status during these periods. The existing evidence does not permit the Arbitrator to conclude that overtime was built into Petitioner's regular schedule, let alone make the necessary calculations.

With respect to average weekly wage, the Arbitrator defaults to the figure Respondent stipulated to, i.e., $1,304.00. That stipulation is binding. Walker v. Industrial Commission, 345 Ill.App.3d 1084 (4th Dist. 2004). The wage of $1,304.00 gives rise to a temporary total disability rate of $869.47.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims the following medical bills: 1) AMCI, $7,643.00; 2) Premium Healthcare Solutions, $4,661.00 (knee and shoulder MRIs performed on January 29, 2016); and 3) EQMD, $1,789.09 (medication prescribed by Drs. Bilko and Agrawal between March 2, 2016 and May 27, 2016). PX 4.

Respondent disputes this claim based on its causation defense and the treatment-related opinions expressed by Dr. Lieber. Respondent established it paid various medical expenses, including EQMD charges in the amounts of $124.94 and $2,570.81. RX 5.

The Arbitrator has previously found that Petitioner established causation as to soft tissue strains which required care through April 27, 2016, the date of Dr. Lieber's Section 12 examination.

With respect to the claimed AMCI bill, the Arbitrator awards the charges through April 27, 2016, subject to the fee schedule. Those charges total $6,956.00. PX 4.

The Arbitrator awards the Premium Healthcare Solutions MRI-related charges of $4,661.00, subject to the fee schedule. PX 4. The Arbitrator finds it reasonable for Dr. Bilko, Petitioner's treating orthopedic surgeon, to have prescribed knee and shoulder MRI scans, given Petitioner's symptoms. Dr. Lieber did not express any criticism of the orthopedic care Petitioner underwent prior to his April 27, 2016 Section 12 examination. RX 4.

With respect to EQMD, the Arbitrator awards only those prescription expenses already paid by Respondent ($124.94 and $2,570.81, RX 5), with Respondent receiving credit for same. A paid medical bill is presumed to be reasonable and Dr. Lieber did not express any criticism of the medication Drs. Bilko and Agrawal prescribed.

Is Petitioner entitled to temporary total disability benefits? Is Respondent entitled to credit for the temporary total disability benefits it paid?

Petitioner claims he was temporarily totally disabled from December 16, 2015 (the date of accident) through the continued hearing of August 10, 2017. Arb Exh 1.

The Arbitrator has previously found that Petitioner established causation as to various soft tissue strains that stabilized, but did not fully resolve, as of Dr. Lieber's April 27, 2016 examination. The Arbitrator adopts Dr. Lieber's opinion that Petitioner required no additional formal treatment for those strains as of April 27, 2016.

The Arbitrator recognizes that the evaluation performed at AMCI on April 27, 2016 showed Petitioner to be functioning at only a light physical demand level. The Arbitrator notes the evaluation took place only two weeks after Petitioner's small bowel resection and during a time when he was complaining of severe fatigue and anticipating chemotherapy. The existing record does not permit the Arbitrator to conclude that the limitations documented by the evaluator stemmed from the work injuries.

The Arbitrator also recognizes that, on May 24, 2016, Dr. Agrawal directed Petitioner to remain off work, pending authorization of the injections. As noted earlier, however, it appears the doctor based this directive, at least in part, on Petitioner's generalized weakness, which prevented him from participating in the work conditioning the doctor had previously recommended. Based on the records in PX 1, the Arbitrator finds it reasonable to infer this weakness stemmed from the cancer-related small bowel resection Petitioner underwent on April 12, 2016 and the chemotherapy he started thereafter. Dr. Agrawal never expressed any awareness of this contemporaneous care. Petitioner clearly remained disabled after April 27, 2016 but he failed to offer any informed medical opinion that this disability stemmed, at least in part, from his work-related injuries.

The Arbitrator finds that Petitioner was temporarily totally disabled from December 17, 2015 (the day after the accident) through April 27, 2016, a period of 18 6/7 weeks. The Arbitrator has

previously found Petitioner's temporary total disability rate to be $869.47, based on Respondent's binding stipulation to an average weekly wage of $1,304.00.

The Arbitrator further finds, based on Martinez's testimony and RX 3 and RX 6, that Respondent is entitled to credit for the $55,761.31 in temporary total disability benefits it paid Petitioner from January 15, 2016 through March 24, 2017. Respondent is also entitled to credit in the amount of $3,353.55 for the full salary it paid Petitioner between the accident and January 14, 2016, but at the temporary total disability rate.

Is Petitioner entitled to prospective care?

Petitioner seeks care in the form of the lumbar epidural injections Dr. Agrawal recommended on April 26, 2016. The Arbitrator declines to award this care. Dr. Agrawal based his recommendation, at least in part, on Petitioner's "intermittent paresthesias", weakness and need for oral narcotics. It appears the doctor attributed these symptoms solely to the work injuries, since he expressed no awareness that Petitioner was undergoing chemotherapy. Dr. Agrawal again recommended the injections on May 24, 2016, noting that Petitioner had missed many work conditioning sessions, due to poor tolerance, and was still using a cane. He again expressed no awareness of the contemporaneous cancer-related care. Petitioner failed to offer any treatment-related opinions from a physician who was aware of his complicated medical situation.