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

Frank Ochoa,

Petitioner,

vs. NO: 15WC 20811

K & M Tire,

18IWCC0125

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 26, 2016, is hereby affirmed and adopted.

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

18IWCC0125

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 - 2018
o022018
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

OCHOA, FRANK
Employee/Petitioner

Case# **15WC020811**

K & M TIRE
Employer/Respondent

18IWCC0125

On 10/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2337 INMAN & FITZGIBBONS LTD
JACK M SHANAHAN
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

18IWCC0125

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(A)

FRANK OCHOA
Employee/Petitioner

Case # 15 WC 20811

v.

Consolidated cases: _____

K & M TIRE
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Arbitrator Doherty**, Arbitrator of the Commission, in the city of **New Lenox**, on **September 12, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. xx 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 5, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$32,194.24**; the average weekly wage was **$619.12**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$19,693.91** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**.

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

ORDER

Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in the treatment of his causally related right knee condition pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any.

Respondent shall authorize and pay for the right knee surgery recommended by Dr. Gokhale and its attendant care pursuant to Sections 8 and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits for a period of 106-1/7 weeks commencing 9/1/14 through 9/12/16. Respondent shall receive credit for amounts paid. ARB EX 1.

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

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

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

Carolyn M. Doherty

Signature of Arbitrator

10/24/16

Date

ICArbDec19(b)

OCT 26 2016

FINDINGS OF FACT

The Arbitrator initially notes that Petitioner claims injury to his right shoulder and his right knee. Respondent does not dispute accident, causal connection, ttd or medical expenses for the right shoulder injury. ARB EX 1. At trial, Respondent disputes accident, causal connection and benefits for Petitioner's alleged right knee injury. Petitioner proceeded to trial under Sections 19(b) and 8(a) of the Act requesting benefits and prospective treatment for Petitioner's right knee. ARB EX 1.

Petitioner, a 42 year old man, testified that in August, 2014, he was employed as a lead supervisor for respondent, K&M Tire, a position he had held for approximately a year and a half. Petitioner testified that he worked over 50 hours per week. As lead supervisor, he had some administrative duties and helped with logistics, but also was responsible for loading and unloading tires as they were delivered, and then stacking them into racks. He testified that the tires would come in shipping containers, and that he and his team of six workers would have to pull them out by yanking them down and then throwing them to another employee who placed them together on a cart that weighed about 150 pounds. When the cart was full of tires, the cart would be pushed to another location. He testified that he would load and unload about 400 tires per day. The work involved physical activity below waist level and above shoulder level and was performed entirely by hand without the use of power jacks.

Petitioner testified that he noticed pain and burning in his right knee while performing these job activities. Specifically, Petitioner testified that he had pain in his right knee at work when bending and then standing back up and when he climbed trucks and racks without using a ladder. Petitioner testified that he did not have prior issues with his right knee. In 2013, Petitioner reported and was treated for a left knee work related injury which is not the subject of this claim.

Petitioner testified on direct examination that he first sought treatment with Dr. Gokhale for his right knee on August 26, 2014. On cross-examination, Petitioner agreed that if Dr. Gokhale's records reflect that petitioner first saw him on August 5, 2014, he would not dispute that. Again, the Arbitrator notes that Petitioner also had right shoulder pain complaints, but the right shoulder is not at issue at trial. The focus is therefore on the disputed right knee condition.

Petitioner's Exhibit 2 is the records of Dr. Gokhale. These records confirm that on August 5, 2014, petitioner presented with complaints of "knee pain right (works for a tire company) – no known injury; hurts a lot to twist at work; anterior/medial pain x 1/1/2 weeks; pops all the time, no locking or giving out; … saw primary and referred to Ortho." Dr. Gokhale noted "… describes right knee pain on the medial side. He notices it when he stands and pivots. It is mainly medial in nature. It can be sharp at times. His right shoulder has also been bothering him, mainly anterolaterally. He lifts tires, hundreds per day and he wonders if that may be contributing to some of the discomfort. …" PX 2, p. 29. A physical exam of the right knee revealed positive McMurray and medial joint line tenderness, full range of motion and no effusion. X-rays revealed mild narrowing of the medial joint space on the contralateral side where he has had prior arthroscopy. Dr. Gokhale assessed right knee internal derangement likely medial meniscus tear. Petitioner was prescribed aspirin and a right knee MRI with a possibility thereafter of cortisone injection or arthroscopy depending on MRI results. PX 2, p. 29.

According to the doctor's records, when petitioner returned on August 26, 2014, he noted that he had gone to the Bolingbrook emergency room for his shoulder over the weekend and was given a note to be off of work for

two days. According to the note, petitioner wanted his off work period extended and a shoulder MRI. With regard to the right knee, the records indicate that Petitioner presented for the MRI but could not receive it because the MRI machine was not working. Dr. Gokhale noted Petitioner "...returned today for follow up. He states that he has been somewhat frustrated unable to get the MRI done on his right knee. We had concern about meniscal tearing similar to what he had on the left side in the past, treated by Dr. Karlsson. We have asked him to come in today to consider cortisone shots into his knee and his shoulder. Again, there was not one specific injury that caused either of these but he believes the possibility of chronic wear and tear at work since he was lifting upwards of 100 pounds at a time doing it chronic repetitive movements with his arms and having to be on his legs all day." (PX 2, p. 25). Petitioner received a right knee cortisone injection.

Petitioner underwent MRIs of the right knee and right shoulder and saw Dr. Gokhale on October 3, 2014 when those were completed. Dr. Gokhale noted that Petitioner was accompanied by a work comp case manager noting "he has submitted the claims as work comp which I thought was reasonable given what he has to do with lifting heavy tires, twisting and turning. He has chronic, repetitive motion to his shoulder and his knees." As regards the knee, Dr. Gokhale noted a signal about the medial and lateral menisci "concerning for a small tear, especially medially. There is mild degenerative change noted." (PX 20). The shoulder MRI showed a full thickness rotator cuff tear along with mild degenerative AC joint changes. Dr. Gokhale recommended a shoulder arthroscopy and rotator cuff repair, and an arthroscopy on the right knee. He noted that petitioner had had an arthroscopy on his left knee previously and had done well from that. Dr. Gokhale also noted that he wanted to do the "knee scope" first, before the shoulder surgery.

On November 12, 2014, Petitioner attended a Section 12 exam with Dr. Verma for Respondent. Dr. Verma noted Petitioner's job with Respondent and the onset of shoulder and right knee symptoms that began in late July or early August 2014. He notes, "He does not describe any specific history of injury or trauma, but notes that he had developed soreness in his right knee and subsequently in his right shoulder..." Dr. Verma also noted that Petitioner "reports that his job description is lifting 70 to 80 pound truck tires. He states that these tires are stacked from floor level to approximately 7 to 8 feet high. He indicates that in order to stack them, they try to bounce them, but are required to lift them overhead and this is done repetitively throughout the day." RX 2. Dr. Verma reviewed an injury report dated 9/10/14 which indicated Petitioner began to feel pain in the right knee and shoulder over a period of time that he felt was related to lifting or handling of tires. On exam, Dr. Verma noted that Petitioner was 6 feet tall and weighed 370 pounds.

Dr. Verma examined the right knee and noted full range of motion with mild pain on forced flexion. He reviewed the right knee MRI noting some intrasubstance signal in the medial meniscus with questionable undersurface tear. Dr. Verma concluded, "diagnosis is questionable right knee medial meniscal tear and right shoulder rotator cuff tear." He concluded, "Based on the patient's job description that requires repetitive lifting including an overhead basis, it is my opinion the right shoulder condition is causally related to the work activities. In regards to the right knee, meniscal tear typically would not be associated with repetitive use mechanism. The patient is not able to provide any specific history of injury or trauma to the right knee. In addition, he has significant morbid obesity, which is a contributing cause to internal derangements of the knee. At this point, it is my opinion that the patient's right knee condition in non work-related." Dr. Verma went on to agree that the recommended right knee arthroscopy was necessary based on the MRI findings but that it was unrelated to the alleged accident. RX 2.

Petitioner underwent the shoulder surgery on December 10, 2014 (PX 5), but respondent has denied authorization under worker's compensation for the knee surgery. Petitioner has not undergone that procedure as of the hearing date. Petitioner commenced postoperative recovery and therapy from the shoulder surgery. Petitioner saw Dr. Gokhale again on January 19, 2015 and right knee surgery was again recommended (Px 3 at

18-19). Dr. Gokhale opined the need for surgery was related to Petitioner's work for Respondent while having to lift tires and twist and turn while loading them (Px 3 at 19). Dr. Gokhale again stated, "... we have reported on several instances that he twists and turns quite a bit at work lifting upwards of 100 pounds and throwing tires back and forth. This has likely led to his shoulder pathology as well as his knee pathology." PX 2. P, 22.
By February 23, 2015 Petitioner was released to light duty work with regard to the shoulder. He continued to progress with regard to the shoulder, undergoing additional therapy. As of April 6, 2015, petitioner was noticing improvement and more strength. Dr. Gokhale ordered work conditioning for four weeks, followed by an FCE. (PX 2, p. 17-34). On May 18, 2015, petitioner was still progressing, but was not at full duty capability yet. Work conditioning was thus continued for another four weeks. He continued his light-duty restrictions, but respondent was unable to accommodate those. As of June 22, 2015, petitioner was capable of lifting up to 70 pounds, and therapy was continued. Petitioner saw Dr. Gokhale again on July 13, 2015 who recommended two more week of work conditioning in addition to a continued recommendation for right knee surgery (Px 3 at 23). With regard to the right knee, Dr. Gokhale noted that the right knee "...continues to bother him on a daily basis with simple twisting and turning activities." PX 2.

Petitioner presented back to Dr. Verma for a second Section 12 examination on July 22, 2015 (Rx 1 at 16). Dr. Verma was in agreement with Dr. Gokhale's recommendation for two more weeks of work conditioning for the right shoulder. This exam was limited to the right shoulder only.

Petitioner was last seen on August 5, 2015 for his shoulder. Dr. Gokhale noted that Petitioner was being seen in follow up for his shoulder but "mainly to discuss his right knee that still continues to give him a great deal of difficulty. He was released from the standpoint of his shoulder after the IME doctor states that he is ready to return to work. Unfortunately, as we had documented all along, the patient has continued to have severe knee pain to the point where daily activities have become painful, and that is likely going to hold him back from work. .... Simple twisting maneuvers cause tremendous pain and this, again, would get in the way of lifting over 100 pounds that is required of him at work." PX 2. Petitioner testified that he has not returned to Dr. Gokhale since, due to worker's compensation denial of treatment for the knee. He continues to receive pain prescriptions from Dr. Gokhale's office.

Petitioner testified he continues to experience right knee burning pain. In order to manage the pain, he takes anti-inflammatory medication as well as Hydrocodone. He expressed a desire to return to work, but he cannot perform his job duties with the pain in his right knee. He continues to want the right knee surgery as recommended by both Dr. Gokhale as well as Dr. Verma.

The parties took the deposition of Dr. Gokhale on 1/14/16. According to Dr. Gokhale, he first saw petitioner on August 5, 2014 with complaints of right knee pain in the medial side that petitioner noticed when he stood and pivoted and it was sharp at times. He also had significant shoulder pain. Petitioner felt that both areas may be related to twisting, turning and lifting hundreds of tires daily. PX 3, p. 8.

His physical examination revealed exquisite medial joint line tenderness in the right knee and a positive McMurray's test, suggesting a meniscus tear. Dr. Gokhale diagnosed internal derangement, likely a medial meniscus tear, and also a rotator cuff tear in the right shoulder. He ordered an MRI of the right knee, which had not been done by the follow-up visit on August 26, 2014. Petitioner again reported that his injuries stemmed from wear and tear of lifting upwards of 100 pounds repetitively, and twisting and turning. P. 11.

The knee MRI was subsequently done and Dr. Gokhale's review of it showed "signal in the meniscal structures, both medial and laterally, but the medial meniscus suggested the possibility of a small tear." p. 12. Dr. Gokhale recommended arthroscopies to both the right knee and right shoulder, and the procedure was performed on the

shoulder on December 10, 2014. The knee surgery has not been performed as it was not authorized by Worker's Compensation. (PX 3, p. 15-19).

Dr. Gokhale opined that there was a causal relationship between the meniscal tear in the right knee and the work performed of twisting and turning, lifting and throwing tires. (PX 3, p. 19). Petitioner continued to recover from his shoulder surgery, and by August 5, 2015, Dr. Gokhale release petitioner to full duty with respect to the shoulder, but he did not release him to return to work on account of his right knee. (PX 3, p. 19–24). Dr. Gokhale agreed with Dr. Verma that morbid obesity can contribute to Petitioner's knee condition but that the nature of Petitioner's work was also a contributing factor. P. 25-26. In explaining, Dr. Gokhale testified "any time your foot is planted and you're twisting, especially if you are lifting weights like tires, that is an abnormal stress and movement on the knee that can injure meniscus structures." Petitioner advised him that the job included chronic repetitive lifting. P 26.

On cross, Dr. Gokhale testified that he could not determine from the MRI whether the tear was recent or chronic. P. 33. He further agreed that the MRI findings of the right knee likely preceded his August 5, 2014 visit with Petitioner. He further agreed that given Petitioner's obesity, the findings in the right knee could have existed without any reported twisting injury and could be just from obesity. P. 34. Dr. Gokhale further testified that "people can develop degenerative meniscal tears over the course of time, and it only starts to affect them out of the blue." He testified that he has seen asymptomatic meniscal tears. P. 36. He disagreed with Dr. Verma and opined "I don't feel like the meniscus tear has to be related to one specific twist or turn. But if it's a part of his daily repetitive activity, that to me would be a concern." P. 35. He opined that the nature of Petitioner's job could or may have aggravated Petitioner's underlying meniscal tear. p. 37.

To the contrary, Dr. Verma testified that the meniscus tear was not traumatic in nature and could not be related to petitioner's employment activities. He confirmed petitioner's history to him during his examination on November 12, 2014 that petitioner had shoulder and knee symptoms that began in July or August 2014, without a specific history of injury or trauma. He summarized his physical examination findings, and noted that the MRI of the knee from September 22, 2014 showed a "questionable tear" in the meniscus with no effusion, and all other ligaments intact. He stated that the "intrasubstance signal [in the MRI] is consistent with degeneration . . .", and it can be difficult to tell "whether that really represents a tear or just degeneration within the meniscus." (RX 1, p.8–11).

Dr. Verma diagnosed a right rotator cuff tear and a questionable right medial meniscus tear. He opined that the job activities petitioner engaged in were not causally related to the findings with regard to the right knee. He based this opinion on the fact that petitioner "did not describe any specific acute injury mechanism that would be typically associated with meniscal tear; I don't know of any data that suggests that repetitive use is associated with meniscal pathology." He also noted that petitioner's age group and obesity are typically associated with knee pain and degenerative pathology such as meniscal tears. (RX 1, p.12-13).

Upon further questioning, Dr. Verma stated that "meniscus tears acutely or traumatically generally occur from a combination of loading, flexion, and rotation. So if you crouch or squat or rotate, you can tear your meniscus. But in order to attribute a tear of the meniscus to that type of activity, it's generally associated with a specific injury mechanism, meaning you do it, you feel a pop or you have pain in the knee, you have subsequent swelling and onset of symptoms. I don't know of data that suggests that doing it on a repetitive basis results in meniscal tearing in the absence of a specific traumatic or acute mechanism. P. 13. He confirmed that petitioner did not report a specific instance of pain in the knee to him. (RX 1, p.13).

He agreed with Dr. Gokhale that it would be impossible to date the findings on the MRI as to when the possible meniscus tear occurred, but that the intrasubstance signal was consistent with degenerative meniscal pathology. (RX 1, p.14). He also opined that with regard to the right shoulder findings on his examination, he diagnosed a rotator cuff tear and felt that this condition was related to petitioner's significant lifting in an overhead position. He agreed that the tear of the rotator cuff is something that can be caused repetitively based on the type of activity being performed. (RX 1, p.14). Dr. Verma agreed that a diagnostic arthroscopy to determine "whether or not there was a tear in the meniscus" would be appropriate, and a tear could be addressed in such a procedure. p.15.

On cross-examination, Dr. Verma noted that the job description that he received for petitioner's position noted a requirement of lifting up to 100 pounds on a continuous basis, but mentioned nothing about twisting and turning. He confirmed that his causation opinion as to the right knee differed from Dr. Gokhale's. Dr. Verma testified that "...meniscal tears when occurring traumatically occur from a twisting or pivoting mechanics, but they are associated with a specific event. Meniscal tears can occur in the general population as a result of degenerative findings which is I think certain the case in this setting, but in don't know that meniscal tears occur as a result of repetitive use in the absence of specific trauma." P. 21. He reiterated that" without a specific history of injury or trauma, there is really no evidence to suggest that because you do an activity it causes a meniscal tear outside of the normal degenerative meniscal pathology that can occur over time related to factors such as obesity, age, arthritis, etc." (RX 1, p.19–22).

Lastly, Dr. Verma stated that the act of taking heavy tires and doing significant twisting could cause a meniscal tear as a single event trauma, but not on a repetitive basis. P, 23. He agreed that someone with a torn medial meniscus could perform the type of job that petitioner described to him, and noted that, "if you take MRIs on all patients beginning at the age of 40, we see an incidence of meniscal tears in asymptomatic patients." As a result, he testified that meniscus tears are not necessarily associated with symptoms, and someone could have one and not realize it. (RX 1, p.22-24).

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

With regard to Issues C, D, date of accident and did an accident occur, and F, causal connection, the Arbitrator finds the following:

The Arbitrator notes that Petitioner credibly testified about the details surrounding his accident and his job duties for respondent. His testimony is unrebutted. Petitioner credibly testified that his job duties include lifting and stacking hundreds of heavy tires each day. His work involves physical activity both below the waist and over the shoulder. His job also involves a significant amount of twisting and pivoting side to side.

The Arbitrator notes that Dr. Gokhale opined that Petitioner's right knee possible meniscal tear is related to his job duties stating, "any time your foot is planted and you're twisting, especially if you are lifting weights like tires, that is an abnormal stress and movement on the knee that can injure meniscus structures." The Arbitrator notes Dr. Verma's agreement that such movement constitutes a mechanism that could result in meniscal tear. Dr. Verma qualified that testimony stating that "...meniscal tears when occurring traumatically occur from a twisting or pivoting mechanics, but they are associated with a specific event. Meniscal tears can occur in the general population as a result of degenerative findings which is I think certain the case in this setting, but I don't know that meniscal tears occur as a result of repetitive use in the absence of specific trauma." He reiterated that "without a specific history of injury or trauma, there is really no evidence to suggest that because you do an

activity it causes a meniscal tear outside of the normal degenerative meniscal pathology that can occur over time related to factors such as obesity, age, arthritis, etc." While agreeing that obesity is a contributing factor, Dr. Gokhale testified "I don't feel like the meniscus tear has to be related to one specific twist or turn. But if it's a part of his daily repetitive activity, that to me would be a concern." While he agreed that obesity can contribute to Petitioner's knee condition he further testified that the nature of Petitioner's work was also a contributing factor. He opined that the nature of Petitioner's job could or may have aggravated Petitioner's underlying meniscal tear.

The Arbitrator further finds Petitioner's right knee condition is causally related to his work duties for Respondent and that his right knee condition manifested on 8/5/14, the day he first saw Dr. Gokhale reporting his right knee symptoms. The Arbitrator further finds that his current right knee condition and need for surgery is also causally related. The Arbitrator's findings are based on the credible, unrebutted testimony of Petitioner regarding his physical job duties, the nature of Petitioner's job duties for Respondent, specifically the twisting and pivoting, and on the more credible and relevant opinion and testimony of Dr. Gokhale given the facts of the record in its entirety.

With regard to Issue J, were the medical services provided reasonable and necessary, and Issue O, petitioner's entitlement to prospective treatment, the Arbitrator finds the following:

Based on the findings on the issues of accident and causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in connection with the care and treatment of his right knee injury pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for all amounts paid, if any. The Arbitrator further finds that Respondent shall authorize and pay for the right knee surgery recommended by Dr. Gokhale and its attendant care pursuant to Sections 8 and 8.2 of the Act.

With regard to Issue K, what temporary benefits are in dispute, the Arbitrator finds the following:

The parties stipulated that petitioner was paid TTD from September 1, 2014 through July 31, 2015. ARB EX 1. Based on the Arbitrator's findings on the issues of accident and causal connection, and on the treatment records containing the off work authorizations of Dr. Gokhale, the Arbitrator further finds that Petitioner was temporarily and totally disabled through 9/12/16, the date of trial. Respondent shall pay Petitioner ttd benefits commencing 9/1/14 through 9/12/16, 106-1/7 weeks. Respondent shall receive credit for amounts paid. ARB EX 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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ALMA GRIMALDO-TOMASELLO,

Petitioner,

vs. NO: 14 WC 15057

CHICAGO PUBLIC SCHOOLS,

Respondent.

18IWCC0126

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, TTD, PPD, and penalties and attorney's fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Decision of the Arbitrator only to disallow some of the awarded medical expenses. These identified expenses are found to be unreasonable, unnecessary, or otherwise not shown to be relatable to Petitioner's February 18, 2014, accident.

Petitioner did not require the additional physical therapy Dr. Garras, her treating physician, prescribed for her on December 4, 2014, as she was discharged from the previously prescribed physical therapy on November 18, 2014, for failing to appear for physical therapy after October 9, 2014. The Commission finds Dr. Garras' renewed prescription for additional physical therapy was premised on the misrepresentation Petitioner made to Dr. Garras of abandoning physical therapy in response to aggravating her right foot and ankle when applying brakes to avoid a motor vehicle accident. The application of the brakes was found to have occurred in late November 2014, more than a month after Petitioner had abandoned physical therapy with Athletico Physical Therapy. The Commission finds further that Petitioner did not require the additional physical therapy prescribed for her by Dr. Garras on December 4, 2014, as

18IWCC0126

she never resumed physical therapy. It is unreasonable to saddle Respondent the $322.46 in physical therapy charges Petitioner blithely incurred after November 18, 2014.

Petitioner claims to have incurred $73,197.40 in medical charges from Midwest Orthopedics at RUSH. The tendered itemization of these charges, prior to any adjustments being made, total $6,652.00 and are relatable to seven physical examinations, four radiology examinations, an MRI, two short-leg casts, a special cast, an ankle stabilizer, a cane, a surgical stocking, a water circulating cold pain with pump, and a walking boot. Absent an explanation how $6,652.00 in incurred services and medical equipment resulted in the claimed $73,197.40 in medical charges, the Commission cannot award medical expenses in excess of $6,652.00.

Petitioner tendered bills into evidence from treatment received from Rush University Medical Center. Of those bills, only the bills from the date of accident and from her preoperative examination with Dr. Henry Danko on May 28, 2014, are found to be causally related to her February 18, 2014, accident. The bills from the date of accident document the treatment Petitioner received from Rush University Medical Center that day and those of Dr. Danko documented the testing she underwent that cleared her for the June 4, 2014, surgery that addressed injuries she sustained on February 18, 2014. The remaining bills, however, concern an x-ray for one of her hands, an unspecified procedure performed by Dr. Adrienne Ray on February 12, 2015, and treatment to an unspecified foot along with bloodwork on May 12, 2015. Petitioner testified that the treatment obtained on May 12, 2015, was a continuation of the treatment begun under Dr. Gallas with a Dr. Meyer acting as Dr. Gallas' successor, but the charges for the services provided on May 12, 2015, named a Dr. Sonali Khandelwal as the attending physician, not Dr. Meyer. Based on the Rush University Medical Center records and bills, only $2,290.80 of the claimed amount is demonstrably related to Petitioner's February 18, 2014, accident.

Petitioner submits three charges from Rush University Medical Group, but only one of these charges is relatable to her February 18, 2014, accident. $256.00 was charged to Petitioner as result of her being seen on the day of the accident by Dr. Edward Ward. $392.00 was charged to Petitioner for services rendered on May 12, 2015, by Dr. Sonali Khandelwal. These charges cannot be reconciled with Petitioner's February 18, 2014, as she received consultation and/or treatment for posterior sclaritis and pain in an unspecified joint. Comparing the medical records from Rush University Medical Group with those from Rush University Medical Center, it is learned that the unspecified joint was, in fact, an unspecified ankle. There is no evidence that the unspecified ankle was the ankle Petitioner injured on February 18, 2014. Furthermore, if it had been the same ankle, the amount of time that had passed between the date of accident and May 12, 2015, makes it impossible, without accompanying medical records, to find any causal relationship between the treatment received on May 12, 2015, and Petitioner's accident from February 18, 2014. The remaining charge of $221.00 stems from Petitioner being seen again by Dr. Khandewal on July 10, 2015, for consultation and/or treatment for posterior sclaritis, esophageal reflux, other and unspecified nonspecific immunological findings, and an "other specific examination." Nothing can be related to any treatment received during this visit to Petitioner's February 18, 2014, accident. Based largely on the lack of corroborating medical records, the Commission finds only the initial charge of $256.00 to be causally related to Petitioner's accident and owed to her by Respondent. It is that amount she claims remains

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unpaid.

The Commission, as noted in the introductory paragraph, modifies the Decision of the Arbitrator with respect to only certain medical charges and affirms and adopts the remaining portions of the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,143.27 per week for a period of 16-2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 50.1 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 30% loss of use of the right foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $127,405.40 for medical expenses under §8(a) and §8.2of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner penalties of $7,584.49, as provided for in Section 16 of the Act, $9,309.48 as provided for in Section 19(k) of the Act, and $10,000.00 as provided for in Section 19(l) of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit 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: MAR 5 - 2018
KWL/mav
O: 01/08/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRIMALDO-TOMASELLO, ALMA
Employee/Petitioner

Case# **14WC015057**

CHICAGO PUBLIC SCHOOLS
Employer/Respondent

18IWCC0126

On 4/26/2017, 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 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:

4642 O'CONNOR & NAKOS LTD
MATT WALKER
120 N LASALLE ST 35TH FL
CHICAGO, IL 60602

0559 CHICAGO BOARD OF ED LAW DEPT
MICHAEL COHEN
10 N DEARBORN ST SUITE 900
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

Alma Grimaldo-Tomasello
Employee/Petitioner

v.

Chicago Public Schools
Employer/Respondent

Case # 14 WC 15057

Consolidated cases: n/a

18IWCC0126

An *Application for Adjustment 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 March 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 _____

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FINDINGS

On February 18, 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 $73,000.00; the average weekly wage was $1,714.90.

On the date of accident, Petitioner was 42 years of age, *married* with 1 dependent children.

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

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

Respondent shall be given a credit of $0 for TTD, $0 for TPD, $0 for maintenance, and $21,057.44 for medical benefits paid to date, for a total credit of $21,057.44..

Respondent is entitled to a credit of $17,920.71 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $172,805.69, as provided in Sections 8(a) and 8.2 of the Act. Of that amount, Respondent has already paid $21,057.44 as of the date of hearing.

Respondent shall be given a credit of $21,057.44 for medical benefits that have been paid pursuant to Section 8 of the Act. Respondent shall be given an additional credit of $17,920.71 for medical benefits paid by Petitioner's group carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,143.27/week for 16 & 2/7 weeks, as follows:
2/19/2014 thru 2/23/2014; 4/19/2014 thru 4/24/2014; 5/2/2014; 5/9/2014; 5/22/2014; 5/28/2014; 6/4/2014 thru 9/8/2014; 9/12/2014; & 10/30/2014 as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 50.1 weeks, because the injuries sustained caused 30% loss of use of the right foot.

Respondent shall pay to Petitioner penalties of $7,584.49, as provided in Section 16 of the Act; $9,309.48, as provided in Section 19(k) of the Act; and $10,000.00, as provided in Section 19(l) of the Act.

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

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

Signature of Arbitrator

04-26-17
Date

APR 26 2017

STATEMENT OF FACTS

ACCIDENT

Petitioner has worked as a Chicago Public School teacher for the past 13 years. *See Transcript,* p.8. She was injured in the course and scope of her employment on February 18, 2014. *See Transcript,* p.12. She had parked her car in the employee designated parking lot, and was walking towards the school building. *See Transcript,* p.13. There was a van turning into the parking lot. *Id.* It swerved a bit, and Petitioner moved out of the way. *Id.* When she placed her foot down, her foot slipped on the ice that had accumulated beneath the snow. *Id.*

Petitioner heard a pop, and felt a pull on the outside of her right ankle. *See Transcript,* p.13. Petitioner was unable to put much weight on her foot. *See Transcript,* p.14. She made it into the building, and reported the accident to the assistant principal. *Id.* Petitioner put some ice on her foot, but her foot continued to swell. *Id.* The school offered to call an ambulance, but Petitioner opted to call her sister-in-law, who picked her up and took her to the emergency room. *See Transcript,* p.15.

MEDICAL TREATMENT

On February 18, 2014, Petitioner was seen at the emergency room at RUSH University Medical Center. *See Petitioner's Exhibit #2,* p.11. The staff noted that Petitioner had injured her right ankle that day at work. The injury mechanism was described as a fall and a twisted joint due to slipping on ice in the school parking lot. The physical exam revealed edema and tenderness to palpation and swelling of the right ankle.

Petitioner followed up with Dr. David Garras at Midwest Orthopedics at RUSH. Her first visit took place on March 19, 2014. *See Petitioner Exhibit #3,* pp.4-5. Dr. Garras recorded the following history: *"Patient states that on February 18, 2014 was walking within the parking lot of her work when she sustained a slip and fall with an inversion injury to her right ankle after stepping on ice. She subsequently presented to the Emergency Room, where x-rays were obtained and did not identify a fracture. She was referred to an orthopedist who treated her for an ankle sprain with an Ace wrap. Since then, she has been weight bearing on the ankle with persistent pain and it has not been improving over the course of the past four weeks. She has noted significant swelling to the region." Id.*

Dr. Garras diagnosed a non-displaced ankle fracture involving the tip of the lateral malleolus below the level of the ankle joint as well as potential injury to the anterior talofibular ligament and the

peroneal tendons, laterally. Physical therapy was ordered. The ordering diagnosis was *"fibula fracture, ankle pain and peroneal tendon injury." See Petitioner's Exhibit #3,* p.7.

Petitioner underwent therapy at Athletico, with the initial evaluation taking place on April 1, 2014. On April 18, 2014, Dr. Garras noted that Petitioner's ankle hurt more after undergoing therapy. She was exquisitely tender over the ATFL as well as the CFL. Dr. Garras opined as follows: *"At this point, I think the patient has not progressed sufficiently and has actually worsened in her symptoms and therefore I would like to obtain an MRI to rule out any additional injury, which may be missed initially including a peroneal tear or an osteochondral lesion, synesmotic injury." See Petitioner's Exhibit #7,* pp.10-11.

Dr. Garras took Petitioner off of work. *Id. at #7,* p.11. The MRI was performed on April 22, 2014. On April 24, 2014 Dr. Garras reviewed the MRI, and noted a split peroneus brevis tear, in addition to the right ankle distal fibular avulsion fracture. Petitioner wanted to pursue nonsurgical treatment, and was placed on restrictions. She was also provided with a knee scooter. *See Petitioner's Exhibit #3,* pp.12-14.

On May 22, 2014, Petitioner was continuing to have significant pain when moving her ankle and when trying to walk. She also began developing pain in her right heel. After speaking with Dr. Garras about her options, Petitioner agreed to surgery. *See Petitioner's Exhibit #3,* pp.19-21.

Surgery was performed on June 4, 2014 at Gold Coast Surgery Center. The surgery consisted of: right ankle arthroscopy with extensive debridement; microfracture of the medial talar dome and lateral talar dome, osteochondral; peroneus brevis debridement; peroneus longus debridement; peroneus brevis repair, Brostrom-Gould lateral ligament reconstruction; amniotic membrane application; and fluoroscopy. *See Petitioner's Exhibit #3,* pp.42-46.

Petitioner followed up with Dr. Garras, and was not released on light duty restrictions until July 17, 2014. At that time, Dr. Garras recommended that Petitioner return to work only if she could be provided transportation to and from work, and was restricted to sit-down work only. *See Petitioner's Exhibit #3,* pp.36-39.

On August 28, 2014, Petitioner was taken out of the cam boot. Physical therapy was being performed at Athletico. Restrictions as of August 28, 2014 consisted of 30 minutes of standing, followed by 30 minutes of sitting. *See Petitioner's Exhibit #3,* pp.42-46. Petitioner was cleared to return to work on October 31, 2014, but was limited to sit down work only. *See Petitioner's Exhibit #1,* p.51. Petitioner was returned to work full duty as of January 8, 2015, with the understanding that she could walk down stairs as tolerated, but should use an elevator when going up stairs. *See Petitioner's Exhibit #3,* pp.57-59.

MEDICAL OPINIONS

Dr. David Garras

Dr. David Garras was Petitioner's treating surgeon. On March 19, 2014, Garras charted that *'Ms. Grimaldo is a 42 year old female that on February 18, 2014 was walking within the parking lot of her work when she sustained a slip and fall with an inversion injury to her right ankle after stepping on ice." See Petitioner's Exhibit #3,* p.4. On that same date, Garras diagnosed Petitioner with *"a nondisplaced ankle fracture involving the tip of the lateral malleolus below the level of the ankle joint as well as potential injury to the anterior talofibular ligament and the peroneal tendons laterally." Id. at* p.4. Garras noted that Petitioner's injury was a workers' compensation injury. *Id. at* p.22.

In the operative report, Garras recorded the following in the paragraph entitled "Indications for Procedure": *'Ms. Grimaldo is a very pleasant 43 year old female who sustained an injury while at work as a schoolteacher to her right ankle. She underwent a period of extensive non-operative management. She then had an MRI, which showed peroneal tear as well as evidence of osteochondral lesion. The patient failed a trial of non-operative management. After reviewing the appropriate imaging and laboratory studies, the above-named procedure was recommended." Id. at* p. 24.

Dr. Henry Danko charted the following on May 28, 2014: *'Fell February 18, 2014 at work and sustained a sprain of the foot. The pain did not abate with conservative treatment. Routine examination and x-rays failed to find structural defects. The MRI did show ligament and tendon damage. She is scheduled for surgical repair on June 4th by Dr. Garras." See Petitioner's Exhibit #5,* p.5.

Respondent had Petitioner examined by Dr. Anand Vora. In his report dated September 25, 2014, Vora opined that *"the work injury on February 18, 2014, was a contributing factor to the current condition."* Vora specifically opined on Page 5 of his report that both the peroneus brevis split tear and the nondisplaced fibular fracture could be related to the work accident. Vora was skeptical of the need for the Brostrom-Gould lateral ligament reconstruction, but this was based solely on pre-surgical diagnostics. In his report, Vora stated he would *"be glad to review the operative MRI and/or review the intraoperative images if indicated"*, but no subsequent report or addendum from Vora was offered into evidence.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner's current condition of ill being is related to the work injury.

To obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuring injuries. *Land & Lakes Co. v. Industrial Commission, 359 Ill. App. 3d 582, 592 (2005).* An accidental injury need not be the sole or principal causative factor as long it was a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Industrial Commission, 207 Ill. 2d 193, 205 (2003).* The court has held that medical evidence is not an essential ingredient to support the conclusion of the Workers' Compensation 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. *See International Harvester v. Industrial Commission, 93 Ill.2d 59, 63-64 (Ill., 1982).*

Based upon the testimony of the Petitioner, the chain of events in this case demonstrates a previous condition of good health, an accident, and subsequent injury resulting in disability. In addition, Dr. Garras, Dr. Danko and Dr. Vora all opine that Petitioner's right foot/ankle condition is related to the industrial accident.

Were the medical services that were provided to Petitioner reasonable and necessary?

The Arbitrator finds that the treatment rendered to Petitioner was reasonable, necessary and related to her industrial accident. The only question raised by Dr. Vora in his report was whether or not the Brostom-Gould lteral ligament reconstruction could be related to the industrial accident. However, Vora's opinions were based solely on the pre-surgical diagnostics. Vora was not provided with the intraoperative films, despite the fact that he indicated he would be glad to review them in his report dated September 25, 2014. The Brostom-Gould ligament reconstruction was performed at the same time as the peroneus brevis repair, as noted in Dr. Garras' operative report.

Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Respondent has paid $21,057.44 towards the outstanding medical bills as of the date of hearing. The Arbitrator finds that all of the treatment rendered in relation to Petitioner's right foot and ankle injury was reasonable and necessary. Respondent shall pay reasonable and necessary medical services of $151,748.25 as provided in Sections 8(a) and 8.2 of the Act. It should also be noted that in

addition to the $21,057.44 paid by the Respondent, Respondent is also entitled to an 8(j) credit in the amount of $17,920.71. All medical charges shall be paid pursuant to the Illinois Workers' Compensation Act Fee Schedule.

What temporary benefits are in dispute?

Temporary Total Disability

Petitioner has proven by a preponderance of the credible evidence that she is entitled to temporary total disability benefits. A claimant is temporarily and totally disabled from the time an injury incapacitates her from work until such time as she is as far recovered or restored as the permanent character of her injury will permit. *Archer Daniels Midland Co. v. Industrial Comm'n, 138 Ill. 2d 107 (1990).* To be entitled to TTD benefits, it is a claimant's burden to prove not only that she did not work, but also that she was unable to work. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n, 236 Ill. 2d 132, 148 (2010).*

Respondent shall pay Petitioner temporary total disability benefits of $1,143.27 week for 16 & 2/7 weeks, commencing on February 19, 2014, and payable at the intervals put forth in the attached order with the final date being October 30, 2014, as provided in Section 8(b) of the Act.

What is the nature and extent of the injury?

With regard to subsection (i) of Section 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 regarding to subsection (ii) of Section 8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a public school teacher at the time of the accident, and that she is able to return to work in her prior capacity as a result of said injury. The Arbitrator notes that Petitioner has difficulty standing for long periods of time, and experiences pain when going up and down stairs. She also has difficulty with ladders. The Petitioner testified that her job duties as a teacher require her to stand throughout the day, go up and down stairs, and has to use ladders when putting up bulletin boards. Therefore, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of Section 8.1b(b), the Arbitrator notes that Petitioner was 42 years old at the time of the accident. Because the Petitioner is a younger individual, she is going to have to work for a longer period of time as a school teacher dealing with the residual symptoms associated with her industrial injury. Therefore, the Arbitrator gives greater weight to this factor.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner has returned to her previous employment. Because Petitioner was not forced to take a job earning less money as a result of the industrial injury, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner testified that she has difficulty standing for long periods of time, experiences pain going up and down stairs, has difficulty using stepladders, and has had to restrict her recreational activity, to include physical exercise. Because Petitioner's testimony is supported by the medical records, 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 to the extent of 30% loss of use of the right foot, pursuant to Section 8(e) of the Act.

Should penalties or fees be imposed upon Respondent?

In cases where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, Paragraph (b) of this Act, shall be considered unreasonable delay. When determining whether this subsection (k) shall apply, the Commission shall consider whether an Arbitrator has determined that the claim is not compensable or whether the employer has made payments under Section 8(j). 820 ILCS 305/19(k).

In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30.00 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000.00. A delay in payment of 14 days or more shall create a presumption of unreasonable delay. 820 ILCS 305/19(l).

Whenever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee, or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of Paragraph (k) of

Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier. 820 ILCS 305/16.

Respondent's failure to pay temporary total disability benefits is unreasonable and vexatious. Dr. Vora served as Respondent's Section 12 examining physician. In his September 25, 2014 report, Vora opined that "the work injury on February 18, 2014, was a contributing factor to the current condition." Vora went on to opine that as related solely to the longitudinal split tear of the peroneus brevis, Petitioner would not reach maximum, medical improvement for six months from the date of surgery. Petitioner's surgery took place on June 4, 2014. The last date claimed by Petitioner for temporary total disability benefits is October 30, 2014, which is less than six months from the date of the surgery.

The Act states that a delay in payment of 14 days or more shall create a presumption of unreasonable delay. The burden of providing a reasonable basis for denial of benefits falls solely on the employer. The Respondent has provided no reasonable basis for the denial of TTD benefits.

As relates to medical charges incurred pursuant to Section 8(a) of the Act, the Arbitrator finds that the Respondent did have a reasonable basis for disputing some of the charges associated with the specific surgery performed, in that Vora did not recommend surgical intervention for conditions other than the longitudinal split tear of the peroneus brevis. Therefore, the Arbitrator declines to award penalties for non-payment of medical charges, noting that the Respondent did pay a portion of the charges incurred by Petitioner at Athletico Physical Therapy, Gold Coast Surgery Center, and Midwest Orthopedics at RUSH.

Respondent shall pay to Petitioner penalties of $7,584.49 as provided in Section 16 of the Act (representing 20% of amounts owed for unpaid TTD plus 20% of the penalties imposed pursuant to Sections 19k and 19l), $9,309.48 (50% of TTD due and owing), as provided in Section 19(k) of the Act; and $10,000.00 , as provided in Section 19(l) 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

Ignacio Martinez,

Petitioner,

vs. No. 14 WC 25882

National Wrecking,

18IWCC0127

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner's application for adjustment of claim alleges that on April 2, 2014, Petitioner injured his left hand and arm "while pulling a heavy cart from elevator." The Arbitrator found Petitioner's De Quervain's tenosynovitis and carpal tunnel syndrome to be causally connected to the accident. For the reasons that follow, the Commission disagrees that Petitioner proved his left carpal tunnel syndrome is causally connected to the accident.

Petitioner testified through a Spanish interpreter that he was right hand dominant. He worked for Respondent as a seasonal laborer. His main job was to dump out gondolas or buckets of debris and trash. A gondola or bucket was about 4 feet long and 5 feet high, weighing "500 pounds or more." It had four wheels and handles. Petitioner dumped approximately 50 gondolas

or buckets a day. Petitioner described the accident as follows: "I picked up a bucket. It was heavy. When it fell, the stuff inside came inside and hit me in my wrist. Then when I went to go dump it, I felt that I had been injured." On cross-examination, when asked to clarify the mechanism of injury, Petitioner stated: "[I]t was in the elevator. I lifted it. I couldn't because it was too heavy. So the whole load and the gondola came on my wrist in the elevator (indicating)."

Respondent sent Petitioner to Occupational Health Centers for treatment. The medical records indicate Petitioner communicated through a translator. On April 2, 2014, Petitioner reported an injury to his left arm, wrist and hand while pushing or pulling a cart at work. He denied direct trauma. The attending physician diagnosed a left wrist and forearm sprain, and prescribed physical therapy and a splint. During follow-up visits, Petitioner complained of persistent pain and swelling in the wrist and distal forearm. On April 29, 2014, Petitioner was referred to a hand specialist.

On May 13, 2014, Petitioner saw Dr. Nicholas Speziale, a hand surgeon. Dr. Speziale noted the following history and complaints: "[The patient] states that he had some falling metal land on his left distal forearm. He states that he is not numb during the daytime. Occasionally, he gets some numbness at night. He does not wake up with this numbness. He does occasionally have weakness. His biggest complaint is pain primarily in the distal forearm. He states sometimes with motion he gets pain that extends from the wrist into the forearm. He went wearing the splint. He feels much better." Physical examination was notable for tenderness over the first dorsal extensor compartment, second dorsal compartment, and the ECU at the wrist. Further, "[h]e is most tender over the distal one-third of the forearm. This is the area where he states he is struck. He is somewhat swollen in this area as well." Dr. Speziale's impression was as follows: "The patient presents after a crush injury to the forearm. He appears to have either contusion or tendinitis involving the extensor tendons." Dr. Speziale recommended wearing a splint full-time and holding off physical therapy. On June 3, 2014, Petitioner followed up with Dr. Speziale, complaining of persistent pain near the radial aspect of the wrist. Physical examination findings were as follows: "[P]atient is still tender over the 1st and 2nd compartments. He has a positive Finkelstein's test. He is having pain with extension of the wrist as well. He also points to an area approximately 4 cm proximal to the dorsoradial wrist where he is having pain." Dr. Speziale diagnosed De Quervain's tenosynovitis and intersection syndrome, and performed an injection into the first and second dorsal extensor compartments. On June 24, 2014, Petitioner reported some improvement after the injections. Physical examination also showed some improvement. Dr. Speziale prescribed physical therapy.

On cross-examination, Petitioner was questioned about the inconsistent histories:

> "Q. [W]hen you saw Dr. Speziale on May 13, 2014, you told him that you hurt your hand when a piece of metal fell on your left wrist and forearm; is that correct?

A. No.

Q. You did not tell Dr. Speziale that you had hurt your left hand while you were pulling a cart?

A. I told him and I will repeat. So, again, I told him I was trying to lift the gondola thing. The load came, the corner of the gondola, and it just hit me against the wrist inside the elevator.

Q. What exactly hit your wrist? The load, something that was in the gondola or the gondola itself?

A. The gondola, the edge of the gondola. So inside the gondola there was a motor and there was other stuff sticking up higher. So it fell to the side and it hit part of the elevator, but it hit me in my wrist.

Q. What hit your wrist?

* * *

What exactly came into contact with the left wrist, the gondola or the debris inside the gondola?

A. The gondola and the wrist."

Petitioner further testified that he switched his care from Dr. Speziale to Dr. Irvin Wiesman, a hand surgeon at Illinois Orthopedic Network. The medical records show Petitioner consulted Dr. Wiesman on July 31, 2014, about left wrist pain. Dr. Wiesman noted the following history and complaints: "The patient works in demolition and states that he was lifting a cart off of an elevator and, when he was going to set it down, the patient's left arm got caught in between the elevator and the cart. He was returned to work. However, the patient was having persistent and severe pain over the dorsal radial aspect of the left wrist and he went back for further treatment." Petitioner reported only temporary improvement from the injections performed by Dr. Speziale and rated the pain a 10/10. Pertinent physical examination findings were as follows: "Full active and passive range of motion of the wrist. Extremely positive Finkelstein's exam. There is evidence of hypopigmentation where the 2 steroid injections were done. [He] has no ECU tenderness, no tenderness along the fovea of the TFC complex. The patient has a negative shuck test, negative Watson's test, and no DRUJ instability. *** Negative Tinel's sign, negative Phalen's sign, and negative carpal compression exam after 30 seconds." Dr. Wiesman diagnosed De Quervain's tenosynovitis, which he causally connected to the work accident, and recommended surgery.

When questioned on cross-examination about the history he gave to Dr. Wiesman, Petitioner agreed that he told Dr. Wiesman on July 31, 2014, he was lifting a cart off an elevator and his left arm became caught between the elevator and the cart.

The medical records further show that on October 28, 2014, Dr. Wiesman performed a left first extensor compartment release. On November 4, 2014, Petitioner followed up, complaining of an 8/10 pain. Dr. Wiesman stated: "I would like to note that, directly before the patient's surgery, he was asking questions about other pain, including numbness, tingling, burning, and weakness of the left hand. He states that all of this has started since 10/31/2014. He has been complaining of loss of sensation." Physical examination findings were as follows: "The incision is well-healed. He is very swollen. Ecchymosis is noted around the incision line. The patient also has abnormal 2-point discrimination with greater than 12 mm along the thumb, index and long fingers of the left hand. The patient also has pain when making a composite fist." Dr. Wiesman ordered electrodiagnostic studies and physical therapy.

On November 11, 2014, Petitioner followed up with complaints of "numbness and tingling along the thenar eminence of the left thumb with numbness and tingling and burning and grip strength weakness." Physical examination findings were as follows: "The incision is well-healed. There is some swelling and bruising noted along the incision line. He has some tenderness. He also has some soreness with Finkelstein's exam. The patient has limited range of motion of the thumb currently due to pain and swelling." Dr. Wiesman noted that Petitioner was to start physical therapy the following day and had electrodiagnostic studies pending "for possible carpal tunnel syndrome." On November 19, 2014, Petitioner underwent the electrodiagnostic studies. The following history was noted: "He reports that he was injured on April 2, 2014, when his left forearm became caught between an elevator and a cart. He experienced instant pain, and when he moved his left arm to push the cart away, the pain increased. He states that he was referred to a clinic by his company and his treatment included wearing a wrist splint, having an injection in his wrist, and therapy. He states that after therapy, he developed a constant sensation of numbness in all of the fingers of his left hand. He states that he was subsequently evaluated at ION, and on October 28, 2014, he had surgical 1st dorsal compartment release done by Dr. Wiesman. He states that the numbness in his fingers has persisted and he has pain with wrist movement. He also reports decreased strength in his left hand." Electrodiagnostic studies, which were performed on the left side only, were "consistent with a mild left median neuropathy at the wrist. This correlates with a clinical diagnosis of mild left carpal tunnel syndrome."

On December 9, 2014, Dr. Wiesman noted: "He is still complaining of palmar pain with burning weakness and redness with significant loss of sensation." Petitioner reported the dorsal radial aspect of the hand was doing well. Dr. Wiesman diagnosed a left carpal tunnel syndrome and recommended surgery. Regarding causation, Dr. Wiesman stated: "Based on a high degree of medical certainty, this is causally related to the patient's job duties."

On April 7, 2015, Petitioner followed up. Dr. Wiesman noted: "The patient continues to have severe numbness of the left hand and the tips of the fingers with grip strength weakness, clumsiness, and a burning sensation and pain. He states that at times the pain does shoot all the way up the arm and into the neck. He continues to have some swelling and difficulties as well along the dorsal radial aspect of the left wrist where he had a first extensor compartment release. He is currently in 9/10 pain." Physical examination findings were as follows: "The incision along the dorsal radial aspect of the left wrist is well-healed. It is swollen. He does have pain with Finkelstein's exam. He has 25 degrees of active wrist flexion and extension. He has a positive Tinel's sign, and positive Phalen's sign. Greater than 12 mm of 2-point discrimination on the radial and ulnar aspects of the first 3 digits of the left hand. Grip strength is 15 pounds." Dr. Wiesman continued to recommend a left carpal tunnel release, and kept Petitioner off work.

On June 2, 2015, Dr. Wiesman noted: "He still complains of inflammation and pain along the first extensor compartment, but he is more concerned with the complete numbness he feels in the thenar aspect of his palm and the first 3 digits of the left hand." Physical examination findings were as follows: "He has a positive Tinel's sign, positive Phalen's sign, some pain with Finkelstein's exam, and some swelling over the first extensor compartment." Dr. Wiesman's recommendations remained unchanged.

On July 14, 2015, Dr. Wiesman noted: "The patient comes in today for a followup evaluation of work related injury where his repetitive motion with wrist flexion and extension and forearm rotation has caused a carpal tunnel syndrome as well as De Quervain's tenosynovitis." Petitioner complained of persistent "significant numbness along the thenar eminence radiating up into the thumb as well as complete numbness in the 2nd and 3rd digits." Physical examination findings were as follows: "Mild pain with Finkelstein examination; however, the pain radiates all the way up into the shoulder. The patient has a positive Tinel sign and positive Phalen sign. Two point discrimination from the thumb to the ring finger is greater than 18 mm. The patient has positive carpal compression examination. Grip strength is 25 pounds." Dr. Wiesman stated: "I do not believe the patient is at MMI. In order for the patient to return back to work full duty, I do believe it is necessary for the patient to undergo this carpal tunnel release," adding: "The patient will refrain from working until completion of treatment." In his work status note, Dr. Wiesman released Petitioner to one-handed duty.

On August 14, 2015, Dr. Wiesman noted: "The patient was involved in a work-related injury. He does repetitive motion of the wrist with repetitive wrist flexion/extension. The wrist flexion/extension is also rapid in nature, therefore he is making this motion several hundred times a day, and patient has developed an overuse injury of tendinitis as well as carpal tunnel syndrome." Petitioner complained of continued burning pain along the first, second and third digits with nighttime paresthesias and weakness. Physical examination was unchanged. Dr. Wiesman continued to recommend a left carpal tunnel release. He kept Petitioner on one-handed duty.

On October 9, 2015, Dr. Wiesman stated Petitioner "developed a median neuropathy as well as tenosynovitis from repetitive and frequent range of motion and forceful grasping and gripping." Petitioner complained of continued numbness and tingling in the palmar aspect of the hand. Physical examination was unchanged. Dr. Wiesman continued to recommend a carpal tunnel release and took Petitioner off work. On November 6, 2015, Dr. Wiesman noted: "He continues to have numbness and tingling and burning pain in the left hand which is significantly worse at night. It also is affecting his grip strength and sensation." Dr. Wiesman performed a steroid injection into the transverse carpal ligament and released Petitioner to return to work on one-handed duty.

On December 18, 2015, Petitioner reported only temporary relief after the injection. "The patient continues to have severe pain throughout the wrist with cramping, stiffness where the hand locks up on him. The hand becomes clumsy and he is often dropping things. He has difficulty making a strong fist." Physical examination was unchanged. Dr. Wiesman continued to recommend a left carpal tunnel release and instructed Petitioner to follow up when surgery is approved. Dr. Wiesman imposed a 5-pound lifting, pushing and pulling restriction on the use of the left hand.

Petitioner testified he last saw Dr. Wiesman on December 18, 2015, explaining that he stopped going to Dr. Wiesman because the insurance did not authorize the surgery. At the time of the arbitration hearing, Petitioner was not working. Petitioner maintained that he had asked Respondent for light duty work, but Respondent did not accommodate his restrictions. Petitioner admitted on cross-examination that as of the accident date, he had been diagnosed as a diabetic for five years. He also admitted to being overweight and having high blood pressure which he stated was controlled with medication.

Dr. Wiesman testified by evidence deposition on January 19, 2016. Dr. Wiesman opined Petitioner's carpal tunnel syndrome was "probably associated with his work," explaining: "[P]er the patient and the history states that he does repetitive motion of the wrist with repetitive flexion and extension, he said several hundred times a day, which we felt was the cause of his tendinitis and most likely brought on the onset of his carpal tunnel syndrome, which did not become apparent till after his surgery." When asked whether the carpal tunnel syndrome was caused by Petitioner's diabetes, Dr. Wiesman responded: "I think it's a combination of both. It could be the combination of them both. But diabetes is systemic, *** if it was solely diabetes, I would expect him to be complaining of it on both sides." When asked whether the carpal tunnel syndrome was caused by postsurgical swelling, Dr. Wiesman responded: "That possibly and having the tourniquet on could have caused enough pressure along the median nerve to make him symptomatic." When again asked for his causation opinion, Dr. Wiesman stated: "I believe that it's related to the whole scenario that occurred. The most precedent issue he was having was with the tendinitis, which was caused by the repetitive use at work. ¶ Subsequently after having the surgery, he started to develop symptoms of carpal tunnel syndrome, which I think was a combination of probably the repetitive use of the hand as well as postoperative swelling and possibly even the use of a tourniquet during surgery to make him symptomatic on that side."

On cross-examination, Dr. Wiesman did not believe he had ever reviewed the medical records from Occupational Health Centers. Dr. Wiesman acknowledged that during the initial visit on July 31, 2014, Petitioner showed no clinical signs of carpal tunnel syndrome. Dr. Wiesman further acknowledged the initial history did not document any repetitive work duties. The first mention of repetitive work duties was not until July 14, 2015, and the first mention of forceful grasping or gripping was not until October 9, 2015. Dr. Wiesman acknowledged that initially Petitioner reported a specific traumatic event. Dr. Wiesman diagnosed De Quervain's, which he initially attributed to "his crush injury." When repeatedly questioned about the inconsistent histories, Dr. Wiesman stated: "[E]verything comes from the petitioner or from the patient." Dr. Wiesman further acknowledged that Petitioner never provided a detailed description of his job activities.

Dr. Wiesman corrected his note of November 4, 2014, to reflect that Petitioner began asking questions about "other pain" "actually starting on the 31st, which would have been a couple days after surgery." Petitioner was addressing new pain that happened after the surgery. The symptoms included numbness, tingling, burning and weakness of the left hand. Dr. Wiesman acknowledged there were no preoperative complaints of numbness and tingling.

Dr. Wiesman further testified on cross-examination that Petitioner was at maximum medical improvement and could return to work full duty with respect to De Quervain's as of the visit on August 14, 2015. Subsequent follow-up visits and restrictions related to the carpal tunnel syndrome only.

Respondent's section 12 examiner, Dr. Charles Carroll, testified by evidence deposition on September 9, 2015. Dr. Carroll, a hand surgeon, testified that he examined Petitioner on October 10, 2014, with assistance from an interpreter. Petitioner "complained of numbness, swelling and pain. He had significant pain over the radial aspect of the wrist, which is around the base of the thumb. He gave a history of pulling a cart and gave a history of striking the volar aspect and the radial aspect of the wrist while trying to pull it from an elevator." Dr. Carroll also noted the history Petitioner gave to Dr. Speziale "of a piece of metal potentially falling on his forearm." Further, Dr. Carroll noted the history Petitioner gave to Dr. Wiesman "of lifting a cart off the elevator and catching his left wrist between the elevator and the cart." Dr. Carroll also noted a history of diabetes and hypertension. Physical examination showed "some bleaching over the left first dorsal compartment and the second and third compartments of the left wrist, which are different tendon compartments near the area of that first injection. He had some swelling. He had some tenderness still in the area of the bleaching." Dr. Carroll continued: "The forearm examination on this date showed the pain over the first and second compartments, which are extensor tendon compartments in the wrist where he had the injections. His Finkelstein sign was quite positive, and that's a test where we put stretch on the tendons to the first compartment by putting your thumb into your palm and putting your wrist towards your baby finger side and stretching those tendons, and that was very painful and diagnostic for his disease state. ¶ His wrist motion showed 60 degrees of palmar flexion, 50 degrees of dorsiflexion. He had some

sensitivity in the area of the median nerve in the wrist. He had 20 degrees of radial and ulnar deviation. There was not any tenderness in the bones. The digital motion was full; and when I looked at the neurologic examination, he had some sensitivity on the Tinel sign on the median nerve, but the Phalen sign and median nerve compression test were negative, meaning he was not diagnostic for carpal tunnel syndrome. ¶ His two point sensation varied between 10 and 15 millimeters. Radial and ulnar nerve function were intact. Grip strength was diminished on the left at 5 pounds versus 60 pounds on the right."

Dr. Carroll diagnosed De Quervain's tenosynovitis and intersection syndrome, as well as numbness in the extremity. Dr. Carroll's causation opinion was as follows: "For the de Quervain's tenosynovitis and the intersection syndrome, I attributed that to the injury that he suffered. For the numbness, I felt that the electrodiagnostic studies would be necessary to clarify what that was further, and it's most likely related to his diabetes." Dr. Carroll thought Petitioner needed a release surgery on the first and second dorsal compartments of the wrist, and the need for the surgery was causally connected to the work injury.

On January 26, 2015, Dr. Carroll reexamined Petitioner. "He noted increasing numbness and tingling and burning, which became permanent after the date of the surgery. *** Therapy had not been effective. The surgery did allow for improvement of his radial wrist pain, which was that de Quervain's tenosynovitis. * * * [The patient] still reported pain that went up the arm toward the shoulder. He noted residual pain and swelling of the forearm. He had loss of sensation in the digits. He did note improvement, though, of the radial-sided wrist pain." Dr. Carroll noted that electrodiagnostic studies showed a left carpal tunnel syndrome. Physical examination was notable for "some residual swelling over the first dorsal compartment of his left wrist which radiated into the forearm. Some tenderness was noted." Also noted was a positive Tinel's sign, but a negative Phalen's sign. The median compression test was now positive. The grip strength was 110 pounds on the right and 15 pounds on the left.

Dr. Carroll diagnosed a resolving De Quervain's tenosynovitis and resolving intersection syndrome, opining that Petitioner would be able to return to his regular work duties in approximately four weeks. Dr. Carroll also diagnosed a left carpal tunnel syndrome, which he related to Petitioner's diabetes. Dr. Carroll could not explain why Petitioner's clinical findings of carpal tunnel syndrome had changed since his previous examination. Dr. Carroll did not see any evidence of significant postsurgical swelling.

Having carefully considered the evidence before us, the Commission finds that Petitioner failed to prove his left carpal tunnel syndrome is causally connected to the work accident. The Commission notes that Petitioner was an inconsistent historian throughout his treatment, and his testimony regarding the mechanism of injury was also vague and inconsistent. Additionally, there is evidence of symptom magnification. Further, Dr. Wiesman's causation opinion is suspect. Although initially Dr. Wiesman noted a history of specific work injury (the forearm becoming caught between the elevator and the cart), he subsequently attributed Petitioner's carpal tunnel syndrome to repetitive motion of the wrist, which was "rapid in nature, therefore he

is making this motion several hundred times a day." In his evidence deposition, Dr. Wiesman acknowledged that during the initial visit on July 31, 2014, Petitioner showed no clinical signs of carpal tunnel syndrome. Dr. Wiesman further acknowledged the initial history did not document any repetitive work duties. The first mention of repetitive work duties was not until July 14, 2015, and the first mention of forceful grasping or gripping was not until October 9, 2015. Dr. Wiesman also acknowledged that Petitioner's carpal tunnel syndrome could be due to his diabetes, "as well as postoperative swelling and possibly even the use of a tourniquet during surgery." Dr. Carroll attributed the carpal tunnel syndrome to Petitioner's diabetes. Dr. Carroll did not see any evidence of significant postsurgical swelling. The Commission is persuaded by the opinions of Dr. Carroll. Accordingly, the Commission vacates the award of prospective medical care and ends the period of temporary total disability on August 14, 2015, the date Dr. Wiesman opined Petitioner could return to work full duty with respect to De Quervain's tenosynovitis.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 11, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $985.72 per week for a period of 54 3/7 weeks, from July 30, 2014, through August 14, 2015, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical care is vacated.

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

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

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

18IWCC0127

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: MAR 5 - 2018
o-01/25/2018
SM/sk
44

Stephen Mathis

Deborah 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 19(b) ARBITRATOR DECISION
CORRECTED

MARTINEZ, IGNACIO
Employee/Petitioner

Case# **14WC025882**

NATIONAL WRECKING
Employer/Respondent

18IWCC0127

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:

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SUITE 1750
CHICAGO, IL 60604

1296 CHILTON YAMBERT & PORTER
DANIEL T CROWE
303 W MADISON ST SUITE 2300
CHICAGO, IL 60606

STATE OF ILLINOIS)SS.

COUNTY OF COOK)

18IWCC0127

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
19(b)

IGNACIO MARTINEZ,
Employee/Petitioner

v.

NATIONAL WRECKING,
Employer/Respondent.

Case # 14 WC 25882

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 **ROBERT WILLIAMS**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **8/30/2016**. After reviewing all of the evidence presented, Arbitrator **MARIA S. BOCANEGRA** hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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 **Medical Treatment under Section 8(a)**

18IWCC0127

CORRECTED FINDINGS

On the date of accident, **4/2/2014**, 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 **$76,886.16**; the average weekly wage was **$1,478.58**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **n/a** dependent children.

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

Respondent shall be given a credit of **$29,992.23** for TTD, **$0** for TPD, **$0** for maintenance, and **$21,634.78** for workers' compensation medical benefits benefits, for a total credit of **$57,627.01**. Respondent is entitled to a credit of **$n/a** under Section 8(j) of the Act.

CORRECTED ORDER

Respondent shall pay for and authorize the prospective left hand/wrist carpal tunnel release as recommended by Dr. Weisman, including any and all incidental care thereto.

Respondent shall pay Petitioner temporary partial disability benefits of **$985.72/week** for **108-6/7th weeks**, commencing **July 30, 2014** through **August 29, 2016**, as provided in Section 8(a) of the Act. Respondent shall be given a credit of **$29,992.23** for TTD.

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

3-28-2017
Date

ICArbDec19(b)

APR 11 2017

CORRECTED BACKGROUND

Ignacio Martinez ("Petitioner") alleged injuries to the left hand/wrist and forearm arising out of and in the course of his employment with National Wrecking ("Respondent"). On August 30, 2016, the parties preceded by agreement before former Arbitrator Robert Williams on the following issues: causal connection, temporary total disability and prospective medical treatment under section 8(a). Jx1. A discussion was had on the record as to Arbitrator Williams' reappointment as Arbitrator and the partics clected to proceed to hearing. In February 2016, the parties by agreement agreed that Arbitrator Maria S. Bocanegra would be responsible for writing the decision in this matter. The following is a recitation of the facts adduced at trial as well as findings of all evidentiary matters into evidence.

CORRECTED FINDINGS OF FACT

Petitioner testified via Spanish interpreter translator Noel Cortez that he was employed as a laborer for the Respondent where he had worked for three seasonal periods. Part of his job included taking buckets or "gondolas" out of elevators. He would take them out and dump them for trash. The gondola was approximately 4 feet wide by 5 feet high, had four wheels and handles for pushing. He estimated he would do this about 50 times per day and that each bucket weighed approximately 500 pounds or more. On April 2, 2014, Petitioner was scheduled to work and in fact did so. During his shift, he picked up a bucket and the bucket fell with the items inside coming toward him and hitting him in his left wrist. He felt a pain and reported his injury. He reported his injury.

On April 2, 2014, Petitioner presented to occupational health centers and related that while at work he was pulling a cart and hurt his left hand. Px1, Rx2. At that time Petitioner weighed 200 pounds and stood 5'5" tall. Medical note noted swelling and tenderness affecting the left wrist. Petitioner related pain increased with lifting and movement, weakness but denied numbness. Other systems were found to be noncontributory or negative to the injury or illness. Assessment was left wrist and forearm sprain. Petitioner was given Biofreeze and cold packs. He was scheduled for modified activity and physical therapy as well as follow-up.

On April 4, 2014, Petitioner returned to Concentra. He complained of moderate pain and swelling of the left wrist and distal forearm. There was no numbness and he noted that he had been pulling heavy cards with one hand. Diagnosis was left wrist and forearm strain the plan was to continue splinting, modified duty with no use of the left arm pending occupational therapy. Petitioner was prescribed ibuprofen, Biofreeze and Norco.

On April 14, 2014, Petitioner returned to Concentra. Assessment was inability to use the left hand as a gross functional assist. The doctor pointed out that Petitioner needed to start occupational therapy in order to prevent disuse atrophy. The plan was to continue splinting, modified duty with no use of the left arm. He was to restart occupational therapy, continue medications and follow-up.

On April 22, 2014, Petitioner returned to Concentra for recheck of the left wrist and forearm sprain. There was no numbness. The doctor again recommended occupational therapy. Plans were unchanged. On April 29, 2014, Petitioner returned to Concentra and saw Dr. Nicholas Speziale, hand surgeon. Px1, Rx3. According to the note, Petitioner related that he had some falling metal land on his left distal forearm. He was not in it during the daytime but did have numbness at night. He reported occasional weakness. His primary complaint was pain in the distal forearm. On exam, ulnar and median motor nerve function was normal and Petitioner had full range of motion of the fingers. There was normal range of motion of the wrist without any

clicking or instability noted. He was tender over the first dorsal extensor compartment, second dorsal compartment and over the ECU at the wrist. The doctor noted crush injury to the forearm with apparent contusion or tendinitis involving the extensor tendons. The doctor recommended holding off therapy and the Petitioner wear the splint full-time. Petitioner was released to light duty and was recommended to follow up.

On May 13, 2014, Petitioner returned to Concentra. Rx4. He related that falling metal landed on his left distal forearm. He did report numbness in the hand at night with occasional weakness. Primary complaint was in the distal forearm. The doctor recommended the teacher hold off on physical therapy and suspected contusion or tendinitis involving the extensor tendons. He was released to light duty and advised to wear his splint at all times. Discussion over injection was had.

On June 3, 2014, Petitioner returned to Dr. Speziale. Petitioner was still tender over the first and second compartments and now had positive Finkelstein test. He was having pain with extension of the wrist as well. Petitioner also reported pain 4 cm proximal to the dorsal radial wrist but was non-tender on the owner aspect of the wrist. The doctor noted persistent tenderness over the first and second dorsal extensor compartment and believe Petitioner had De Quervain's tenosynovitis and intersection syndrome. Petitioner was injected over the dorsoradial wrist and over the second dorsal extensor compartment. He was given a thumb SPICA splint to immobilize the wrist and thumb. He was released to return to work light duty and advised to follow up. On June 24, 2014, Petitioner returned to Dr. Speziale. Petitioner reported improvement with movement of the wrist with occasional pain. Petitioner also reported that his work has been difficult and was aggravating his pain in the wrist. He also reported a small bump in his wrist. The doctor recommended home exercise program and scar massage. He was released to return to work with no more than three powerlifting and was advised to wear the splint at work. He was to avoid forceful grasping.

On July 31, 2014, Petitioner first presented to Dr. Irvin Weisman of ION Clinics. Px2, Rx5. He was evaluated for the left wrist pain status post work-related injury. Petitioner related that he was lifting a cart off of an elevator and when trying to set it down the left arm got caught between the elevator and the cart he felt immediate pain and was eventually diagnosed with a sprain. Petitioner stated that following the injection 72 hours later the pain returned. Petitioner also complained of a small hardball along the extensor tendon sheath. There was full and active passive range of motion of the wrist. Finkelstein's exam was positive. The doctor noted a palpable ganglion cyst over the EPL tendon of the left hand. Petitioner had no ECU tenderness and there was positive Tinel's and Phalen's testing. There was negative carpal compression exam after 30 seconds. Assessment was left De Quervain's tenosynovitis. The doctor noted that Petitioner failed conservative treatment including continuous splinting and a thumb SPICA splint, anti-inflammatories as well as steroid injections to the first and second extensor compartment spaces. The doctor opined that Petitioner's condition was work-related. The recommendation was for surgical correction with the first extensor compartment release. Petitioner was released to light duty. On September 19, 2014, Petitioner returned to Dr. Weisman who noted ongoing pain in the left wrist mostly on the dorsal radial aspect. Recommendations were unchanged. He remained on light duty.

On October 10, 2014, Petitioner saw Dr. Charles Carroll for a section 12 exam at the request of the Respondent. Thereafter, surgery was authorized for De Quervain's syndrome. On October 28, 2014, Petitioner underwent and Dr. Weisman performed a left first extensor compartment release to address left De Quervain's.

On November 4, 2014, Petitioner returned to Dr. Weisman following surgery. The doctor noted that Petitioner was very swollen and had abnormal two-point discrimination with greater than 12 mm along the thumb, index and long fingers of the left hand. The doctor noted that Petitioner was also reporting symptoms of

numbness, tingling, burning and weakness of the left hand. The plan was for EMG of the bilateral upper extremities and to begin physical therapy. He remained off of work.

On November 11, 2014, Petitioner returned to Dr. Weisman. He was complaining of numbness and tingling along with thinner eminence of the left thumb with numbness, tingling, burning and grip strength weakness. The doctor noted Petitioner was awaiting EMG to evaluate for possible carpal tunnel syndrome. He was released to light duty and advised to follow up. On November 19, 2014, EMG of the left upper extremity was consistent with mild left median neuropathy at the wrist correlating with a clinical diagnosis of mild left carpal tunnel syndrome.

On December 9, 2014, Petitioner returned to Dr. Weidman for the left hand. He complained palmar pain with burning weakness, redness and significant loss of sensation. On exam, grip strength was weak and compared to the right and there was positive Tinel's and Phalen's. Assessment in part was left carpal tunnel syndrome. The recommendation was for left carpal tunnel release due to significant weakness and loss of sensation. He remained off of work. The doctor opined that the condition was causing related to Petitioners job.

On January 26, 2015, Petitioner saw Dr. Carroll a second time at the request of Respondent. Dr. Carroll stated that the EMG/NCV showed evidence of left carpal tunnel syndrome. Dr. Carroll eventually testified on September 9, 2015 that as a result of his physical examination and his review of the medical records, he diagnosed resolving De Quervain's tenosynovitis, resolving intervention symptoms, and carpal tunnel syndrome. As to what caused the diagnosis of left carpal tunnel syndrome, Dr. Carroll stated the Petitioner's diabetes and obesity. Dr. Carroll unequivocally stated that the work accident did not in any way cause or contribute to the cause of the left carpal tunnel syndrome. Dr. Carroll testified that Petitioner did not have left carpal tunnel syndrome when he first examined the Petitioner. Dr. Carroll testified that the surgery did not cause the Petitioner's left carpal tunnel syndrome. Dr. Carroll reviewed Dr. Weisman's surgical report and post-surgical records and saw no evidence of post-surgical swelling, which could be a factor in causing carpal tunnel syndrome. Further, Dr. Carroll testified that there was no evidence of a crushing injury to the Petitioner's radial side of the left wrist on 4/2/14.

On April 7, 2015, Petitioner returned to Dr. Weisman for follow-up of left De Quervain's tenosynovitis and left carpal tunnel syndrome. Petitioner continued with severe numbness of the left hand and the tips of the fingers with grip strength weakness, clumsiness, burning sensation in pain. Exam showed positive Tinel's and Phalen's. Grip strength was 15 pounds. Recommendations were unchanged. Petitioner remained off of work.

On June 2, 2015, Petitioner returned to Dr. Weisman in follow-up unchanged. Petitioner still complained of inflammation and pain along the first extensor compartment and numbness in the thinner aspect of his palm and the first three digits of the left hand. Physical exam was unchanged. The doctor recommended a repeat steroid injection into the first extensor compartment to reduce inflammation and to resume therapy. Petitioner still awaited left carpal tunnel surgery. He remained off of work.

On July 14, 2015, Petitioner again returned to Dr. Weisman. The doctor noted that repetitive motion with wrist flexion and extension and forearm rotation has caused a carpal tunnel syndrome as well as De Quervain's tenosynovitis. There was positive Tinel's, Phalen's and carpal compression exam. Grip strength was 25 pounds. The doctor continued to recommend carpal tunnel release. Meloxicam, Protonix and gabapentin were refilled. Petitioner was to continue wearing carpal tunnel splint and ordered to discontinue therapy because he has plateaued. Petitioner remained off of work.

On August 14, 2015, Petitioner again returned to Dr. Weisman. The doctor continued to endorse repetitive and overuse injury. Physical exam and recommendations were unchanged. Petitioner was released to return to light duty.

On October 9, 2015, Petitioner returned to Dr. Weisman. Exam and recommendations were unchanged. Petitioner was taken off of work. On November 6, 2015, Petitioner returned to Dr. Weisman. Exam and recommendations were unchanged. Petitioner underwent a cortisone shot in the transverse carpal ligament. He was released to return to work with no use of the left hand. On December 18, 2015, Petitioner returned to Dr. Weisman for the final time. At that exam, physical examination was unchanged and recommendations were unchanged. Petitioner was cleared for light duty.

On January 19, 2016, the parties took the evidence deposition of Dr. Weisman. Px3. The doctor testified that he believed Petitioner's De Quervain's was causally related to his work. The doctor also testified that he believed that the cause of Petitioner's carpal tunnel syndrome was repetitive motion of the wrist several hundred times a day which he felt was the cause of the tendinitis and most likely brought on the onset of carpal tunnel syndrome which did not become apparent until after surgery but that the cause was multi-factorial. The doctor opined testified he did not believe it was diabetes as a contributing cause or factor as he would expect to see it on both sides. The doctor testified that Petitioner's carpal tunnel syndrome could have been caused as a result of the postsurgical swelling by having a tourniquet cause enough pressure along the median nerve. The doctor admitted that none of his previous notes documented what Petitioner's job duties were and whether those duties were repetitive. The doctor continued to recommend carpal tunnel release but stated that Petitioner was at MMI for De Quervain's.

Petitioner testified that prior to this injury he never had sustained any other injury or serious work accidents, sporting accidents, accidents at home and otherwise considered himself a healthy individual. Petitioner admitted to being diabetic and having high blood pressure. Petitioner denied having any prior left arm pain before the work accident. At trial, Petitioner admitted to having pain and discomfort. Under cross-examination, Petitioner admitted to being diabetic on the date of the accident. On that date he stood 5'6" tall and weighed 210 pounds. Petitioner recalled being told by his primary care physician to lose weight in order to help with his diabetes. Petitioner clarified that on the date of the incident, he attempted to lift the gondola while in the elevator and in doing so the load in the gondola came down on his wrist in the elevator.

Petitioner agreed that he was paid temporary total disability benefits from July31st, 2014, through March 28, 2015. Petitioner testified that he could not recall when he returned to Respondent's place of work to ask for employment within his restrictions. He testified that he came to the front desk and gave his paperwork to a woman who then gave them to a man named Matt.

CORRRECTED CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator was not present during the trial testimony of Petitioner, who was the only witness to testify at trial. However, the Arbitrator finds Petitioner to be credible based upon the trial transcript as well as the medical records introduced into evidence.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. After considering the record as a whole, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that his current condition of the ill being as it relates to his left declare veins tenosynovitis and left carpal tunnel syndrome is causally related to his work accident. As a matter of clarification, the parties do not seriously dispute whether Petitioner's left De Quervain's was caused by his work accident. Nevertheless, the Arbitrator finds that under chain of events theory, Petitioners left De Quervain's is causally related to his work accident. In support thereof, the Arbitrator relies on Petitioner's credible testimony that prior to the date in question, he had no left hand or wrist symptoms and had not been previously diagnosed with left De Quervain's. Moreover, the Arbitrator's conclusion as to the left De Quervain's is consistent with Petitioners treating physicians all of whom suspected the De Quervain's as well as Respondent's physician, Dr. Carroll, who opined that the condition was in fact causally related.

The crux of the dispute between the parties on this issue centers around whether Petitioner's left carpal tunnel syndrome is causally related to his work accident. In so concluding that it is, the Arbitrator relies again on Petitioner's specific testimony that he had no prior problems with the left hand or wrist prior to the date in question. Moreover, the mechanism of injury as Petitioner credibly related at trial was that the gondola struck his left hand or forearm area when he attempted to pull it out of the elevator. The description of this direct and immediate trauma to the left hand area is supported by Petitioner's medical records. The Arbitrator does note, however, that Dr. Wiseman toward the end of the treatment record began to endorse a repetitive or overuse theory that neither was asserted by Petitioner or any other record in this case. Consistent with this observation is Dr. Weisman's agreement that he noted no prior repetitive trauma or job duties before the left De Quervain's surgery. To that end, the Arbitrator will disregard that portion of Dr. Wiseman's opinions. Instead, the Arbitrator adopts and relies on the medical opinions of Dr. Weisman previously noting that Petitioner's left carpal tunnel syndrome is causally related to his work accident, which began after the De Quervain's surgery. Again, such a finding is supports a chain of events theory that Petitioner's mechanism of injury ultimately led to acute carpal tunnel syndrome that manifested itself after surgery. The record shows that while treating with Concentra, Petitioner began complaining of numbness at night in the wrist area. Petitioner also began complaining to Dr. Weisman of numbness, tingling and weakness in the left hand before after surgery. Px2.

In rejecting Dr. Carroll's opinion that Petitioner's left carpal tunnel syndrome was caused by his diabetes and weight, the Arbitrator notes that Dr. Weisman persuasively countered this theory, stating that since diabetes is systemic, you would expect to see CTS in both hands rather than one. Moreover, Dr. Carroll stated that there was no post-surgical swelling, which he agreed could account for the CTS, but the record demonstrates Petitioner had significant swelling following De Quervain's surgery. Px2.

ISSUE (K) ***Is Petitioner entitled to any prospective medical care?***
ISSUE (O) ***Other Medical Treatment under Section 8(a)***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the issue of causation as it relates to carpal tunnel syndrome, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that he is entitled to prospective medical care. Specifically, the Arbitrator finds that Petitioner is entitled to a left carpal tunnel release as recommended by Dr. Weisman. Dr. Weisman did note during his deposition that at that time there was no additional treatment being recommended for the De Quervain's which he believed had reached maximum medical improvement.

In so finding that Petitioner is entitled to such prospective medical care, the Arbitrator relies on Petitioner's treatment and medical notes which document a failure of conservative care as to the left wrist and carpal tunnel syndrome. Moreover, neither Dr. Weisman nor Dr. Carroll have opined that Petitioner has reached maximum medical improvement as to the left carpal tunnel syndrome, regardless of causation. Therefore, because Petitioner has not reached maximum medical improvement as to the left carpal tunnel syndrome, Respondent shall pay for and authorize the recommended treatment for the left carpal tunnel syndrome as outlined by Dr. Weisman, including any and all incidental care there to.

ISSUE (L) What temporary benefits are in dispute?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the issues of causal connection and prospective medical care, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he is entitled to further additional temporary total disability benefits. In so finding, the Arbitrator relies on the medical opinions of Dr. Weisman, which document that Petitioner has failed to improve in terms of the left carpal tunnel syndrome and has been in need of ongoing restrictions to the left hand and or wrist until such time as the carpal tunnel syndrome is resolved. Petitioner's unrebutted and credible testimony was that he attempted to secure light duty work with the woman at the front desk, who in turn gave his document to Matt. Respondent failed to rebut this was any proof of an offer of light duty employment. Therefore, Respondent shall pay Petitioner temporary partial disability benefits of **$985.72/week** for **108-6/7th weeks**, commencing **July 30, 2014** through **August 29, 2016**, as provided in Section 8(a) of the Act. Respondent shall be given a credit of **$29,992.23** for TTD.

Signature of Arbitrator

3-28-2017
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

Roy Brooks,

18IWCC0128

Petitioner,

vs. NO: 17 WC 15854

Quality Mechanical, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of accident, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2018, is hereby affirmed and adopted with the changes noted above.

18IWCC0128

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: MAR 6 - 2018
o3/1/18
DLS/rm
46

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0128

BROOKS, ROY
Employee/Petitioner

Case# **17WC015854**

QUALITY MECHANICAL INC
Employer/Respondent

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:

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

4412 AF GROUP
GRACE Di GERLANDO
PO BOX 40785
LANSING, MI 48901-7985

18IWCC0128

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)

Roy Brooks
Employee/Petitioner

v.

Quality Mechanical, Inc.
Employer/Respondent

Case # **17** WC **15854**

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 **July 17, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **4/26/17**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this 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 **$89,440**; the average weekly wage was **$1,720.00**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Because the Arbitrator finds that the Petitioner failed to prove that he sustained a compensable accident that arose out of and in the course of Petitioner's employment with the Respondent, all benefits are denied.

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

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

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

Signature of Arbitrator

08-29-17
Date

ICArbDec19(b)

AUG 29 2017

ROY BROOKS V. QUALITY MECHANICAL, INC.
CASE NUMBER: 17 WC 15854

FINDINGS OF FACT:

On July 17, 2017, this matter was tried before Arbitrator Carlson at the IWCC in Chicago. The petitioner was the first and only witness to testify on his own behalf. He testified that on April 25, 2017, he was employed by Quality Mechanical (hereinafter referred to as the respondent) as a sheet metal worker/service technician and that he had worked for the respondent for a little over a year at that time. The petitioner testified that as a sheet metal worker he was usually on construction jobs and as a service technician, he was provided with a company vehicle.

The petitioner testified that prior to April 25, 2017 he had never injured his lower back. He testified that he previously injured his neck 20 or 25 years ago at work, but that he only attended physical therapy for the same. The petitioner testified that on April 25, 2017 he was working for the respondent as a sheet metal worker (i.e. installing duct work, thermostat wire, thermostats and base board heating) at Main Park Leisure Center in Park Ridge, IL. He testified that he arrived at the job site at 5:00 am and he was the only employee of the respondent working on that site on April 25, 2017.

The petitioner testified that on April 25, 2017, he was climbing a ten foot ladder to get inside a crawl space to install thermostat wire when the right hand side of the ladder broke, twisted the petitioner to the right and he "went back and landed" with his "back against a stack of ladders" then landed on his feet. (TX 16) He testified that he fell 5 to 6 feet and landed on both of his feet. The petitioner testified that he was stunned, but he shook it off and kept working. He testified that he completed his work day and "wasn't really hurting at all." (TX 17)

The petitioner testified that on April 25, 2017, Harry Spaulding, the respondent's driver, came to the job site about one hour after his injury occurred. He testified that Mr. Spaulding came to drop off baseboard heat. The petitioner testified that he was injured at approximately 11:00 am on April 25, 2017 and he spoke with Mr. Spaulding at approximately 12:00 pm. He testified that he gave Mr. Spaulding the broken ladder, requested that he bring it back to the shop, and that he advised Mr. Spaulding of what had occurred.

The petitioner testified that he returned to the same job site on April 26, 2017 and that he felt okay on that date. He testified that he worked a full day and returned to the same job site on April 27, 2017. The petitioner testified on April 27, 2017 he noticed that his right leg was numb. He then testified that if he went back to Wednesday when he was lying in bed at approximately 8:00 pm he began to notice numbness in his left thigh and like his left foot was falling asleep. The petitioner testified that he worked the entire day on April 27th and at the end of the day he was beginning to "get a little sore in his neck and his right thigh was kind of getting numb." (TX 22)

The petitioner testified that at approximately 5:00 pm on April 27, 2017, Dan McKay, the respondent's superintendent, called him and advised him that he was being taken out of service and that he would strictly work construction. After the aforementioned was discussed, the petitioner testified that he informed Mr. McKay about his accident on Tuesday.

The petitioner testified that he worked at the same job site on Friday, April 28, 2017. He testified that Mr. McKay was also on the site on April 28th along with Mr. Brian Jordan. The petitioner testified that he filled out an accident report at Main Park Leisure Center on April 28th and that he informed Mr. McKay of the same. (PX 1) He testified that he was scheduled to work until 1:00 pm on that date, but he only worked until

10:00 am, so that he could start cleaning out the van and return it to the shop. The petitioner testified that he had to clean out the van because a new service guy had been hired to take over his service position. Although he would lose the company vehicle, he testified that he did not consider this a demotion as his pay would remain the same.

The petitioner testified that he was not scheduled to work on April 29th or 30th of 2017. He testified that over the weekend his back and neck began to stiffen up, but his numbness seemed like it went away. The petitioner testified that he reported to work at the UIC Hospital on May 1, 2017 and that Mr. McKay was on site. He testified that at approximately 10:00 am, on that date, he began experiencing numbness in his right thigh again. The petitioner testified that Mr. McKay had left the site to get material, so he telephoned Mr. McKay and advised him of his numbness and Mr. McKay advised him to go to the office. He testified that he filled out an injury report at the respondent's office on May 1st. (PX 2)

The petitioner testified that on May 1st he drove from UIC to the respondent's office in Thornton, IL, which took approximately 45 minutes. He testified that the date of accident noted on petitioner's exhibit #1 was April 26, 2017. The petitioner testified that the aforementioned was a mix up and that his injury actually occurred on April 25, 2017. (PX1) The petitioner testified that he also noted an accident date of April 26, 2017 on the accident report he filled out at the respondent company; however, he again testified that he was injured on April 25, 2017. (PX 2) He testified that he knew he was injured on a Tuesday, but he did not have the correct date. The petitioner testified that Matt, his boss and the owner of the company, was present when he filled out the accident report on May 1, 2017. He testified that he had not spoken to Matt about his accident prior to that date and that it was clear to him that Matt first learned of his accident on May 1st..

The petitioner testified that he attempted to go to Pinnacle Hospital on May 1st, but they would not evaluate him without a claim number, so he returned on May 2nd. He again testified that he incorrectly informed the hospital of the wrong accident date of accident as he still thought Tuesday was April 26th. The petitioner testified that he was authorized off of work on May 2nd and that May 1st was his last day of work.

The petitioner testified that he was examined by Dr. Kanuru on May 18, 2017 and that injections and physical therapy were recommended. He testified that he began physical therapy at Machen Therapy and Sports Medicine on May 22nd and that he was examined by Dr. Alexander Ghanayem, his second choice of doctor, on June 5, 2017. The petitioner testified that he was not able to proceed with the injections recommended by Dr. Kanuru as they were not authorized by workers' compensation. He testified that he was still awaiting approval for his injections and that he would like to continue with the recommended care. The petitioner testified that he had not received any temporary total disability benefits and that he had not been released to return to work in any capacity. He testified that he had not re-injured his neck or back in any way since April 25, 2017.

On cross examination, the petitioner testified that on April 25, 2017, he was climbing up a ladder when the ladder collapsed and he went backwards, up against ladders that were chained upright, and came down on his feet. He testified that he did not experience any pain at that time.

On cross examination, the petitioner testified that on April 25, 2017, Harry Spaulding came to his job site and he advised Mr. Spaulding of his injury. He testified that Mr. Spaulding took the ladder that he was allegedly injured on away. The petitioner testified that he did not speak with Mr. McKay, his supervisor, on April 25th or 26th and that he first spoke with Mr. McKay on April 27th. He testified that on April 27, 2017, Mr. McKay informed him that he would no longer be required to work as a service technician and that another individual would be coming to the site on April 28th to relieve him of his job duties.

On cross examination, the petitioner testified that on April 28, 2017, Mr. McKay and Mr. Jordan came to the job site at Main Park, so that Mr. Jordan could assume his position. He testified that he was no longer going to be working in the service tech department because an individual with more knowledge had been hired. The petitioner testified that he was not upset about this change or about the fact that he would be losing his company vehicle. He testified that his change in position meant that he would be driving his own vehicle to and from work. The petitioner testified that the company vehicle and the gas and insurance for the same was paid for by the respondent, which would no longer be the case.

On cross examination, the petitioner testified that on April 28, 2017, he thought Tuesday was April 26th. He testified that he knew the 28th was a Friday, but, again, he thought Tuesday was the 26th. The petitioner testified that he did not experience back or neck pain on April 25th. He testified that he continued to work his full duty job that entire week.

On cross examination, the petitioner testified that as of May 1, 2017, he was strictly working as a sheet metal worker. He testified that he recalled receiving text messages from Mr. Milliagan regarding I Pass issues while he was at UIC or on his way to the office on May 1st. The petitioner then testified that he did not recall if he received texts from Mr. Milligan concerning discrepancies between what his I Pass receipts were showing and where he was allegedly working on May 1st. He testified that Mr. Milligan sent "him something on that," but he "didn't think it was anything." (TX 52) The petitioner testified that he may have received the texts on May 1st, but he did not know what time it was and he did not know what date Mr. Milligan was referring to.

On cross examination, the petitioner testified that Dr. Ghanayem did not request that he return for a follow up examination and that he was currently only treating with Dr. Kanuru. He testified that he had not been evaluated by any other physicians. The petitioner testified that he did not recall informing Mr. Michele Goff (during his recorded statement) that his entire back spasmed when he was injured 20 years prior.

On cross examination, the petitioner testified that he knew that if he was injured at work he was to report the injury immediately. He testified that he was not collecting temporary total disability, unemployment, social security or short term disability benefits. On redirect examination, the petitioner testified that he did not report his injury right away on April 25, 2017 because he had fallen off ladders before and it usually went away.

On examination by the Arbitrator, the petitioner testified that he brought his MRI films and reports to his appointment with Dr. Ghanayem. He testified that the ladder broke at the area that held the bars together and the ladder twisted. The petitioner testified that Harry Spaulding took a picture of the ladder a week after the incident. The photograph of the ladder was viewed by all parties and the Arbitrator commented that the cross brace appeared separated, but the ladder did not look like it was damaged in any way. The petitioner testified that the ladder could be repaired.

Mr. Matthew Milligan testified on behalf of the respondent company. He testified that he was the president and owner of the respondent company since 2003. Mr. Milligan testified that his job duties were to oversee the operation of the company and that he had approximately 30 employees. He testified that the respondent company was a mechanical contractor and they provided sheet metal, piping and HVAC services.

Mr. Milligan testified that he was familiar with the petitioner because he was hired by Mr. Dan McKay of the respondent company in the summer of 2016. He testified that the petitioner was hired as a sheet metal worker and that he claimed to have some service background and knowledge, so he was to be used as a service technician as needed. As a sheet metal worker, Mr. Milligan testified that the petitioner would install duct work and equipment and as a service technician he would diagnose and make repairs. Mr. Milligan testified

that he did not know the petitioner prior to his date of hire. He testified that, typically, the petitioner worked from 7:00 am to 3:30 pm, Monday through Friday.

Mr. Milligan testified that the petitioner was working at the Main Park Leisure Center on April 25, 2017 and that he was working alone. He testified that the petitioner worked the entire day on April 25th and that he worked the entire day, performing the same job duties at the same location on April 26, 2017. He testified that the petitioner worked every day that week, performing his regular job duties, until he left to clean out his truck at 11:00 am on April 28, 2017.
Mr. Milligan testified that he became aware of the petitioner's pending worker's compensation claim against the respondent when the petitioner came to the office on May 1, 2017 and requested an accident report. He testified that April 25, 2017 was a Tuesday and that the petitioner did not inform him or anybody that worked for him that he was injured on April 25, 2017 nor did the petitioner inform him or anybody that worked for him that he was injured on April 26, 2017. He testified that, to his knowledge, nothing of significance occurred on April 25, 2017.

Mr. Milligan testified that on April 26, 2017, Mr. Harry Spaulding, the respondent's driver, delivered material to Main Park Leisure. Following that delivery, Mr. Milligan testified that Mr. Spaulding did not inform him that the petitioner had injured himself. He testified that the petitioner worked the entire day performing his full duties on April 27, 2017. On that date, Mr. Milligan testified that he advised Mr. McKay to instruct the petitioner that he would solely be working in the sheet metal department and that they would be giving the petitioner's company supplied service vehicle to another employee. Mr. Milligan testified that the petitioner lost his service technician position due to performance issues and because there was an obvious lack of knowledge on the services that the petitioner was performing. He testified that the petitioner was to return the company van in the next couple of days. Mr. Milligan testified that Mr. McKay did not tell him that the petitioner reported any injury at that time.

Mr. Milligan testified that if an employee was injured, the company protocol was for the injury to be reported immediately to your supervisor or directly to Mr. Milligan. Once the incident was reported, he testified that the injured worker would be directed to fill out an accident report. Mr. Milligan testified that the petitioner's loss of the service technician position did not decrease his pay, but resulted in a loss of transportation to work. He testified that the respondent provided gas and insurance for the company vehicle and that the petitioner would no longer have the same. Mr. Milligan testified that the petitioner "wasn't thrilled" about losing his service tech position as he lost a benefit, a perk. (TX 73)

Mr. Milligan testified that on April 28, 2017, Mr. Brian Jordan went to the job site to perform a transfer of responsibility where Mr. McKay oversaw the handoff of the job from the petitioner to Mr. Jordan. He testified that on April 28, 2017, the petitioner informed Mr. McKay that he hurt his back earlier in the week and Mr. McKay advised him to fill out a report. Mr. Milligan testified that Mr. McKay prepared a written statement during the week of May 1, 2017 upon his request. Mr. Milligan testified that if there were questions as to what happened, he would request that the same be clarified in writing as part of the ordinary scope of the respondent's business. He testified that Mr. McKay prepared the report at or about the time of the petitioner's alleged accident and that he had knowledge of the information contained within the report. Mr. Milligan further testified that it was a regular part of the respondent's business to keep and maintain records such as Mr. McKay's written statement. (RX 2)

Mr. Milligan testified that the petitioner was off of work on April 29th and 30th of 2017 because it was the weekend. Over the weekend, Mr. Milligan testified that the petitioner texted him because there was a service call and Mr. Milligan informed the petitioner that he would handle the same. During the aforementioned text

messages, Mr. Milligan testified that the petitioner did not inform him of any injury that allegedly occurred the prior week. Mr. Milligan testified that the petitioner dropped off the respondent's van on Sunday.

Mr. Milligan testified that the petitioner reported to work at UIC at 6:00 or 7:00 a.m. on May 1, 2017. That morning, Mr. Milligan testified that he was looking at the petitioner's time sheet and the petitioner put down a couple of hours for cleaning out the van, which Mr. Milligan questioned. He testified that he also questioned the petitioner about some inconsistencies between his time, I-Pass and gas receipts, which were conflicting. Mr. Milligan testified that there were times that the petitioner said he was at a job, but he was going through the I-Pass miles from the job. He testified that there were also times that the petitioner had written himself in at a job when he was clearly getting gas. Mr. Milligan testified that he had the aforementioned information because of petitioner used a company vehicle. He testified that he did not believe that the petitioner ever really responded to his texts and the next thing he knew, the petitioner arrived at the shop to fill out an accident report. Mr. Milligan testified that the aforementioned texts were sent at approximately 9:00 a.m. and the petitioner arrived at the shop around 11:00 a.m. He testified that he first learned of the petitioner's alleged accident when the petitioner arrived at the shop on May 1, 2017.

Mr. Milligan testified that, on May 1, 2017, the petitioner informed him that he injured his back at Main Park when he slipped off of a ladder, "or something of the sort." (TX 82) He testified that the petitioner did not tell him that he filled out an accident report at Main Park, but that the petitioner e-mailed a copy of the accident report that was prepared at Main Park to him roughly a month after the alleged incident. He testified that he did not know why the petitioner would fill out an accident report at the district and not with his employer. Mr. Milligan testified that he did not see the petitioner between April 24th and May 1st of 2017 and that the petitioner did not report any accidents to him at any time prior to May 1, 2017.

Mr. Milligan testified that on May 1, 2017, the petitioner appeared "inconsistent." (TX 84 and 85) He testified that the petitioner said his back hurt, but he was doing things that Mr. Milligan felt he could not do if his back was hurt. Mr. Milligan testified that the petitioner was squatting next to a file cabinet when he was waiting for his report. He testified that the petitioner was very comfortable squatting and he was able to maintain and hold that position while he waited in the shop. A photograph taken of the petitioner filling out the accident report on May 1, 2017 was viewed and exhibited the petitioner squatting down and filling out a chart. Mr. Milligan testified that he took the aforementioned photograph because, in his opinion, the petitioner's claim was inconsistent with his behavior.

Mr. Milligan testified that he had seen the ladder in question. He testified that, by trade, he was a member of the Pipe Fitters Union as a service technician. Mr. Milligan testified that he had been a member of the Pipe Fitters Union since 1991 and that in his position as a piper fitter and through his work experience, he had been on a lot of ladders. He testified that he could not see how a ladder would collapse if it broke and one hinge was still intact. If the ladder was set up properly, Mr. Milligan testified that the weight would be down with the work in front or above you. He testified that the weight would be straight down on the ladder and there would be no reason for the ladder to twist unless an individual twisted it or leaned off of it. Mr. Milligan testified that he did not see how the ladder collapsed without causing damage to the ladder. He also testified that the hinges would be twisted if the ladder had collapsed.

Mr. Milligan testified that respondent's exhibit #1 was Mr. Spaulding's written statement and that he believed he received the same the morning of May 2, 2017. (RX 1) He testified that Mr. Spaulding provided him with his written statement of his own free will. Mr. Milligan testified that he asked Mr. Spaulding where the ladder was on May 1, 2017 because the petitioner claimed he had fallen off of it. He testified that Mr. Spaulding asked him why he wanted to know about the ladder and Mr. Milligan informed Mr. Spaulding that the

petitioner claimed he had fallen off the ladder. He testified that Mr. Spaulding went home and the following morning he handed him a written statement and advised Mr. Milligan that it had been bothering him. (RX 1)

On cross examination, Mr. Milligan testified that he was not at the Main Park or the UIC job site. He testified that he did not know what actual job duties the petitioner performed on April 25th, 26th, 27th or 28th, just that he was on the job site on those dates. Mr. Milligan testified that he was not present for the petitioner's encounter with Mr. McKay. He testified that the petitioner complied with turning in the company vehicle and that the petitioner had removed his personal tools from the vehicle. Mr. Milligan testified that the petitioner had mentioned a back injury to Mr. McKay as of April 28, 2017. He testified that once an injury is reported to a supervisor, the supervisor should handle the same.

On cross examination, Mr. Milligan testified that it was the petitioner's responsibility to keep the company vehicle filled with gas and that it was to be filled on his way to work, not half a hour after his shift began. He testified that it was not the company standard to pay someone to fill the company vehicle with gas. If the petitioner came to the shop to pick up materials, Mr. Milligan testified that he would be on the clock at the time that he picked up the material.

On cross examination, Mr. Milligan testified that Mr. Spaulding showed him the ladder that the petitioner gave to him. He testified that he briefly looked at the ladder and saw the broken hinge. Mr. Milligan testified that if you were standing on the ladder and all four feet were on the ground and one hinge was off, all four feet would still be anchored to the ground unless you shifted your weight. Again, he testified that he just did not see how the ladder collapsed. Mr. Milligan testified it stood to reason that a ladder would be more likely to twist with one hinge as opposed to two.

The next witness to testify on behalf of the respondent company was Mr. Harry Spaulding. Mr. Spaulding testified that he was a driver for the respondent and that he had worked for the respondent for approximately 4 years. He testified that his job duties included delivering material to job sites. Mr. Spaulding testified that he was familiar with the petitioner because he also worked for the respondent. He testified that he did not know the petitioner prior to his employment with the respondent.

Mr. Spaulding testified that he was aware that the petitioner was alleging that he was injured at work on April 25, 2017. He testified that he became aware of the same the Monday after the alleged incident when Mr. Milligan asked him where the ladder in question was. Mr. Spaulding testified that he did not see the petitioner on April 25, 2017, but that he saw him on April 26, 2017. He testified that he arrived at the site at approximately 9:30 am on April 26th. Mr. Spaulding testified that, at that time, the petitioner picked up a pallet, weighing approximately 35 to 40 pounds, off of the ground by himself and brought it inside the room and set it on the ground. After that, Mr. Spaulding testified that he and the petitioner proceeded to unload material off the back of the truck. Mr. Spaulding testified that the petitioner did not inform him that he had fallen off of a ladder at any time. After the material was unloaded, Mr. Spaulding testified that he drove around to the dumpster and the petitioner picked up an eight foot pallet off of the back of the truck and threw it up into the dumpster by himself. Mr. Spaulding testified that once the pallet was thrown into the garbage, the petitioner informed him that he had a broken ladder that he wanted Mr. Spaulding to bring back to the office. He testified that the petitioner got the ladder off of the top of his vehicle by himself and put it onto Mr. Spaulding's truck. Mr. Spaulding testified that at no time during this interaction did the petitioner inform him that he had fallen off of the ladder.

Mr. Spaulding testified that respondent's exhibit #1 was a copy of his handwritten statement that he signed. (RX 1) He testified that no one asked him to prepare the statement, but he prepared the same after Mr. Milligan asked him about the broken ladder and he began to think about it. Mr. Spaulding testified that he

recalled seeing the petitioner the prior Wednesday and he "seemed to be okay. There's no problem. He didn't say that he fell off the ladder or anything..." (TX 114) Mr. Spaulding testified that he did not see or speak with the petitioner after April 26, 2017. He testified that the petitioner sent him a text on Friday, April 28th, and requested a picture of the broken ladder. Mr. Spaulding testified that as of the date of this trial, the petitioner had never told him that he had fallen off of a ladder.

On cross examination, Mr. Spaulding testified that he did not have any interactions with the petitioner on April 25, 2017 and that he interacted with the petitioner on Wednesday, April 26, 2017. He testified that he did not make any other deliveries to Main Park during that week. Mr. Spaulding again testified that he was sure that he saw the petitioner on April 26, 2017.

On re-direct examination, the petitioner testified that his accident occurred on, Wednesday, April 26, 2017 at 11:00 am. He testified that he dragged the pallet, but did not lift the pallet that Mr. Spaulding testified about. The petitioner testified that he never claimed time worked when he was not working. He testified that he was squatting on May 1, 2017 because there was no where to sit. The petitioner testified that it seemed like his injury was getting worse and worse and that he was still able to squat.

On cross examination, the petitioner testified that his injury occurred on a Wednesday. The petitioner was provided with a transcribed copy of his recorded statement taken on May 5, 2017 to review. He testified that on May 5, 2017, he swore that his accident occurred on Tuesday, April 25, 2017. The petitioner testified that he was confused at that time.

Upon questioning by the Arbitrator, Mr. Spaulding testified that he was 70 years old and that he received a pension and social security benefits. He testified that he was not currently working because he took the summer off and he was able to do the same due to his pension and social security. Mr. Spaulding testified that he liked to work and that if he lost his job he may find another part time job. Mr. Spaulding testified that his wife did not work and that he does not forget where he parks his car.

MEDICAL FACTS:

On May 2, 2017, the petitioner was evaluated at the Pinnacle Hospital Urgent Care. Reportedly, on April 26, 2017, the petitioner fell into a pile of ladders while on a ladder at work. He complained of neck and back pain. X-rays taken of the lumbar spine exhibited degenerative disc disease at L5-S1 with moderate disc height loss. X-rays of the cervical spine exhibited straightening of the cervical spine without radiographic evidence of acute osseous injury. The petitioner was assessed with neck and back pain and MRIs of the cervical and lumbar spine were recommended. Tylenol #3, Voltaren Gel and a Medrol Dose Pac were prescribed and the petitioner was authorized off of work until cleared by a specialist. (PX 4)

On May 12, 2017, the petitioner underwent a cervical MRI, which exhibited some disc bulging at C5-6 and spondylosis into the right foramen producing mild right foraminal narrowing. No other abnormality was noted. On that same date, the petitioner also underwent a lumbar MRI, which exhibited some minor disc bulging and right subarticular recess and foraminal narrowing at L4-5. There was "rather severe disc degeneration at L5-S1 with discogenic marrow change and a small annular tear." Reportedly, there was also minor inferior right foraminal narrowing with minor contact on the exiting right L5 nerve root. (PX 4)

On May 18, 2017, the petitioner was evaluated by nurse practitioner Megan Colburn at the Kanuru Interventional Spine and Pain Institute. He complained of pain in the neck with no radiation, pain in the right shoulder blade, and pain in the right lower lumbar and thoracic spine. The petitioner reported that when he drove, he experienced numbness in the right thigh and when he laid down, he experienced occasional

numbness in the left lower extremity that stopped at the foot. It was noted that his pain began on April 25, 2017 when he was climbing a 10 foot ladder to crawl into a soffit. The petitioner alleged that the right side of the ladder was broken and the ladder fell, causing him to fall into a row of ladders and land on his feet. Reportedly, he went to work the next day and reported the injury to his foreman and filled out an accident report on April 27, 2017. It was noted that on May 1st, the petitioner was allegedly at UIC Hospital climbing a ladder when he felt his neck "throbbing." He allegedly advised his foreman that he wanted to fill out a "company report, so his foreman sent him to the shop." (PX 5)

Following his evaluation on May 18, 2017, the petitioner was diagnosed with cervical spondylolisthesis, "infection of the intervertebral disc (pyogenic) of the cervical region," lumbar disc displacement, bulging at C5-6, cervical spondylosis, right cervical facet joint syndrome, cervicalgia, annular tear of L5-S1, right lumbar radiculopathy at L5 distribution and right lumbar foraminal narrowing at L4-5. Limbrell and Flexeril were prescribed along with physical therapy. An epidural steroid injection at C5-6 was also prescribed. (PX 5)

On May 22, 2017, the petitioner underwent an initial physical therapy examination at Machen Therapy and Sports Medicine, LLC. The petitioner complained of neck and lower back pain and reported a "traumatic fall on April 25, 2017, while at work…" He continued to attend therapy through at least July 10, 2017. (PX 6)

On June 5, 2017, the petitioner was evaluated by Dr. Alexander Ghanayem. Reportedly, on April 25, 2017, the petitioner's ladder broke causing him to fall backwards into another ladder, but he was able to remain on his feet. He complained of neck and back pain and denied any prior spine problems. The petitioner's cervical MRI was reviewed and Dr. Ghanayem noted that the same exhibited no evidence of disc herniation, deformity or listhesis, but mild spondylosis was at C6-7. According to Dr. Ghanayem, the petitioner's lumbar MRI of the exhibited degenerative changes, more so at the L5-S1 level where he had degenerative disease with Modic changes. After examining the petitioner and reviewing his films, Dr. Ghanayem diagnosed him with a cervical strain and lumbar degenerative disc disease. Dr. Ghanayem recommended that the petitioner continue to focus on conservative care regarding his range of motion and pain. It was noted that he would follow-up with his pain management specialist as well to discuss the possibility of epidural injections. The petitioner was to follow up with Dr. Ghanayem on an "as needed basis." (PX 7)

IN SUPPORT OF THE ARBITRATOR'S DECISION PERTAINING TO (C) WHETHER AN ACCIDENT OCCURRED THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT WITH THE RESPONDENT AND (D) WHAT WAS THE DATE OF THE ACCIDENT, THE ARBITRATOR FINDS THE FOLLOWING :

The Arbitrator finds that the petitioner failed to prove by a preponderance of the credible evidence that he sustained accidental injuries while working for the respondent on April 26, 2017. An injury is compensable under the Illinois Workers' Compensation Act only if it arises out of and in the course of employment. Pangos v. Industrial Commission, 171 Ill.App.3d 112, 524 N.E.2d 1018 (1988). The burden is on the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. Peoria County Nursing Home v. Industrial Commission, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). The burden is also on the employee to prove that his injuries are causally related to the employment. Newgard v. Industrial Commission, 58 Ill.2d 164, 317 N.E.2d 524 (1974). The mere existence of testimony does not require its acceptance. Bernard v. Industrial Commission, 25 Ill.2d 254, 184 N.E.2d 864 (1962).

Critical to the aforementioned is the petitioner's credibility and the weight of his testimony depends upon the same. Once the petitioner's credibility is questioned, the concept of truthfulness becomes crucial. The Arbitrator notes that compensation has been denied by the Commission and affirmed by the Courts in numerous instances when the claimant's credibility was suspect and the contemporaneous medical histories

conflicted with and/or failed to corroborate the claimant's testimony. See Elliott v. Industrial Commission, 303 Ill.App.3d 185, 707 N.E.2d 228 (1999); McRae v. Industrial Commission, 285 Ill.App.3d 448, 674 N.E.2d 512 (1996); Banks v. Industrial Commission, 134 Ill.App.3d 312, 480 N.E.2d 139; Luby v. Industrial Commission, 82 Ill.2d 353, 412 N.E.2d 439 (1980). Furthermore, when an Arbitrator finds that a petitioner has lied on a particular issue, the arbitrator may then find the petitioner is not credible as to other issues. Parro v. Industrial Commission, 167 Ill.2d 385, 657 N.E.2d 882 (1995).

The Arbitrator notes that in a disputed accident claim and in determining the credibility of the testimony presented at hearing, it is necessary to carefully consider the testimony of all witnesses in light of any contemporaneous documentation presented at the hearing. The petitioner alleges that his accident was not witnessed, which, alone, is not remarkable. However, when a work accident is not witnessed, the petitioner's credibility becomes crucial as he is the only person who is able to verify what occurred. The petitioner failed to present any witnesses to verify his accident or his account of his accident. The two witnesses presented by the respondent (i.e. the owner/president of the company and the respondent's delivery driver) testified that they did not witness the petitioner's alleged accident nor did they have any knowledge that the petitioner was allegedly injured on April 25th or 26th of 2017, dependent upon which date of accident you chose, until after the petitioner lost his position as a service technician for the company. While it is true that the respondent employs the aforementioned witnesses, the Arbitrator notes that they appeared truthful and impartial while testifying.

The Arbitrator finds that the petitioner's testimony to be inconsistent and contradicted by respondent's witnesses as well as the medical evidence. The petitioner's testimony was contradicted too many times to support a compensable claim. Furthermore, the Arbitrator finds that the petitioner only claimed to have suffered a work accident after he lost his company vehicle and position as a service technician. Although this was not a termination per se, it was a loss of a position and it is well recognized that the reporting of accidents subsequent to termination may negatively impact the credibility of accident claims. Bullock v. SSM/Good Samaritan Hospital, 2009 IWCC 805.

Initially, the petitioner testified that he was injured at approximately 11 am on April 25, 2017, when the right hand side of his ladder broke and he fell back against other ladders, landing on his feet. He testified that on that same date, he advised Mr. Spaulding of his injury. He denied experiencing any pain at the time of his injury and testified that his pain did not begin until the evening of April 27, 2017 when he was lying in bed. The petitioner worked the entire week of April 24, 2017 and, by his own testimony, did not report an injury to anyone until the evening of April 27th when the respondent's superintendent, Mr. McKay, advised him that he would be losing his company vehicle and service technician position. The petitioner was adamant that his accident occurred on a Tuesday, which was April 25, 2017, and that when he filled out his accident reports and noted an injury date of April 26, 2017 he was merely mistaken on the date. However, he knew that his injury occurred on a Tuesday.

Mr. Spaulding testified that he did not see the petitioner nor did he go to the job site that the petitioner was at on April 25, 2017. He testified that he saw the petitioner at the job site at approximately 9:30 am on April 26, 2017. According to Mr. Spaulding, not only did the petitioner lift and unload a pallet at that time, he also threw the pallet into a dumpster by himself. Although Mr. Spaulding admitted that the petitioner gave him a broken ladder, which the petitioner took off of his own vehicle by himself and put it onto Mr. Spaulding's truck, on April 26th, he testified that the petitioner never informed him that he had fallen off of the ladder or that he was injured. Per the petitioner's own testimony, he did not experience any symptoms on April 25th or 26th of 2017. Thus, it is difficult for the Arbitrator to believe that he sustained any traumatic injury on either of those dates.

The Arbitrator notes that only after hearing the testimony of the respondent's witnesses did the petitioner amend his Application to reflect an injury date of April 26, 2107. Interestingly, April 26th was a Wednesday and prior to hearing the testimony of respondent's witnesses, the petitioner was adamant that his injury occurred on a Tuesday. Furthermore, after the petitioner changed his date of injury to April 26, 2017, he continued to insist that his injury occurred at 11:00 am. However, Mr. Spaulding testified that he met with the petitioner at approximately 9:30 am on April 26th and, at that time, he was provided with the broken ladder in question.

The Arbitrator notes that Mr. Spaulding's testimony is in direct contradiction to the testimony of the petitioner and the Arbitrator finds the testimony of Mr. Spaulding to be credible. Furthermore, the Arbitrator believes that Mr. Spaulding arrived at the job site at 9:30 am on April 26, 2017 and, thus, that it would be impossible for the petitioner to have fallen off of the broken ladder at 11 am on that same date. Additionally, the Arbitrator finds the petitioner's sudden change in date of injury following the testimony of the respondent's witnesses to be highly suspect. Additionally, the Arbitrator notes that the petitioner's medical records from physical therapy, Dr. Kanuru's office and Dr. Ghanayem's office note a date of injury of April 25, 2017. (PX 5, 6 and 7) Based upon the aforementioned, the Arbitrator finds the petitioner's testimony to be mistaken in fact.

The Arbitrator also finds the testimony of Mr. Milligan to be credible. By the petitioner's own admission, Mr. Milligan did not learn of the petitioner's alleged injury until May 1, 2017. Mr. Milligan testified that the petitioner did not appear at the office on May 1, 2017 until after Mr. Milligan questioned him about discrepancies between his time sheets and I Pass and gas receipts. Of note is that Mr. Milligan and the petitioner exchanged texts over the preceding weekend and on May 1, 2017 and at no time did the petitioner report that he was injured at work. The Arbitrator also agrees with Mr. Milligan in how he fails to comprehend how the petitioner's ladder could have collapsed and twisted to the right, without the ladder itself sustaining damage. (PX 8) Furthermore, the Arbitrator agrees with Mr. Milligan in that the petitioner's behavior (i.e. no noted pain until 2 days after the alleged injury, uncertainty over the day of injury, no report of an injury until the loss of his service tech position / service vehicle, working full duty and full time for 3 days post the alleged injury, squatting for an extended period on May 1, 2017, etc.) was inconsistent with his allegation that he was injured on April 26th of 2017.

The Arbitrator also notes various inconsistencies in the petitioner's medical records and his own testimony. Although the petitioner testified that his pain did not begin until the evening of April 27, 2017, on May 18, 2017 he informed nurse practitioner Colburn that his pain began on April 25, 2017. (PX 5) Interestingly, at this same examination, the petitioner reportedly informed nurse practitioner Colburn that while he was climbing a ladder at work at UIC on May 1, 2017, he felt his neck "throbbing" and informed his foreman of the same. (PX 5) However, at the time of trial, the petitioner testified that while at UIC on May 1st, he began to experience numbness in his right thigh and he allegedly informed Mr. McKay of the same. Again, the Arbitrator finds the testimony of the petitioner to be in direct contradiction to his contemporaneous medical records.

After reviewing the evidence and observing all of the witnesses, the Arbitrator finds that the petitioner failed to meet his burden of proof and establish that he suffered from an accident on April 26, 2017. The petitioner continued to work his full time regular duty job from April 25th through April 28th of 2017 and did not seek medical care until May 2, 2017, after he was confronted by Mr. Milligan. The Arbitrator finds the testimony of the respondent's witnesses (Mr. Milligan and Mr. Spaulding) to be credible and finds that the petitioner did not sustain a compensable injury that occurred during the course and scope of his employment with the respondent company.

The Arbitrator finds that the petitioner's credibility was seriously drawn into question based upon the testimony of the respondent's witnesses, the petitioner's failure to report a work related injury pursuant to the respondent's normal policy and procedure, the inconsistencies in his reported date of injury, his failure to seek treatment until after he lost his position as a service technician and his company vehicle and was questioned regarding time sheet discrepancies, etc. Under the aforementioned circumstances, the Arbitrator can only find that the petitioner failed to meet his burden of proof. Thus, the Arbitrator finds that the petitioner did not suffer from an accident, which arose out of the course and scope of his employment with the respondent on April 26, 2017.

IN SUPPORT OF THE ARBITRATOR'S DECISION PERTAINING TO (F) IS THE PETITIONER'S CURRENT CONDITION OF ILL BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS THE FOLLOWING:

As the Arbitrator finds that the petitioner did not suffer from an accident that arose out of the course and scope of his employment on April 26, 2017, the issue of causal connection is moot. For the foregoing reasons, the Arbitrator finds that there is no casual connection between the petitioner's condition of ill-being and the alleged accident of April 26, 2017.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (J) WHETHER THE RESPONDENT HAS PAID ALL APPROPRIATE CHARGES FOR REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS THE FOLLOWING:

As the Arbitrator finds that the petitioner did not suffer from an accident on April 26, 2017 and that his current condition of ill being is unrelated to said alleged accident, the Arbitrator finds that the respondent is not liable for the payment of any of the petitioner's outstanding medical expenses. The Arbitrator notes that this issue was set aside at the time of trial.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (K) IS PETITIONER ENTITLED TO PROSPECTIVE MEDICAL CARE AND (L) WHAT TEMPORARY TOTAL DISABILITY BENEFITS ARE OWING, THE ARBITRATOR FINDS THE FOLLOWING:

As the Arbitrator finds that the petitioner did not sustain an accident that arose out of the course and scope of his employment on April 26, 2017 and, furthermore, finds that the petitioner's current condition of ill being is not causally related to his alleged injury, the issues of prospective medical care and temporary total disability benefits are moot and the Arbitrator finds that the petitioner is not entitled to either.

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

Angelina Cahue,
Petitioner,

18IWCC0129

vs.

NO: 11 WC 5723

Tootsie Roll Industries,
Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

MAR 6 - 2018

DATED:
o3/1/18
DLS/rm
046

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

18IWCC0129

CAHUE, ANGELINA
Employee/Petitioner

Case# 11WC005723

TOOTSIE ROLL INDUSTRIES INC
Employer/Respondent

On 7/17/2017, 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 1.12% 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:

1315 DWORKIN AND MACIARIELLO
KATHERINE EXO
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CHICAGO, IL 60602

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18IWCC0129

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

Angelina Cahue
Employee/Petitioner

Case # 11 WC 5723

v.

Consolidated cases: _____

Tootsie Roll Industries, 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 **George Andros** , Arbitrator of the Commission, in the city of **Chicago** , on **November 28, 2016 and June 26,2017** . After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 2, 2010** , Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$32,961.02**; the average weekly wage was **$633.87**.

On the date of accident, Petitioner was **63** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$none** for TTD, **$none** for TPD, **$none** for maintenance, and **$none** for other benefits, for a total credit of **$none** .

Respondent is entitled to a credit of **$5,173.80** under Section 8(j) of the Act.

ORDER

The Arbitrator finds as a matter of fact and law that the Petitioner did not have an accidental injury arising out of her employment. For this reason, all claims for benefits under the Illinois Workers Compensation Act are 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.

#001 George J. Andros — Signature of Arbitrator

July 12, 2017 — Date

JUL 17 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Angelina Cahue
Employee/Petitioner

Case # 11 WC 5723

v.

Tootsie Roll Industries, Inc

THE ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

(1) THE PETITIONER'S TESTIMONY

The Petitioner testified on November 28, 2016 and June 26, 2017. She testified through an interpreter.

Ms. Cahue testified that she worked for Tootsie Roll for 34 years. She had done many jobs over the course of the 34 years. More recently, she had been operating machinery. The machine required her to take candy in heavy boxes, maybe about 40 pounds.

On November 2, 2010 she was on the second shift which is 3:25 pm to 11:55pm. She was working on the machine that makes candy. She ran out of material so she was sent to the machine that makes boxes. She had worked this machine that makes boxes on previous occasions. She said she was stacking boxes. A worker puts cardboard into the top of the machine and the machine makes boxes. On this evening, the petitioner said, a mechanic was feeding the machine. Then another worker has to stack the boxes. On this evening the petitioner was stacking boxes. On this evening , some of the boxes coming out of the machine were good. Some of the boxes were not good. The petitioner said the machine was malfunctioning. The petitioner said she had been throwing the bad boxes on the side of the machine. The floor is made of cement.

The Petitioner said her foot got caught in the crack then she said she stepped on a box with her right foot and she felt a crack in the right ankle. She pointed to the front or anterior aspect of the right ankle. The Petitioner said she held herself on the handles of the machine. The machine had a ladder and she grabbed the handles by the ladder.

The Petitioner said she did not feel anything right away except she felt a crack or a pop. She went to sit down.

It was just about lunch time. The workers eat lunch in the basement. They have to walk there. The Petitioner said she was struggling trying to walk.

She was having pain at the top of the ankle. She traced a semi-circle around the lower end of the tibia. The Arbitrator noted that she had swelling below the right lateral malleolous. But he said he would defer to medical evidence as to the significance of that observation.

The Petitioner said she did go to lunch and after she went to work at a difference place.

The Petitioner spoke to the manager. The Petitioner said that Teresa Sanchez was present when she spoke to the manager. Teresa speaks Spanish. Ms. Cahue said that the manager grabbed her hand and took her to the door and called a taxi.

There were other people who saw her. The Petitioner said the guard called the taxi and the taxi took her to a clinic.

The Petitioner recalled going to Concentra on November 2, 2010. She testified that she told a person at Concentra what had occurred. The conversation was in Spanish. The question was, whether she said "I was walking and I twisted my right ankle." The Petitioner said she did say that. At Concentra the Pctitioner spoke with a person who spoke Spanish.

The Petitioner said that at the clinic the doctor performed some type of examination. The doctor saw the foot and twisted the foot. X-rays were taken that day.

She saw the doctor again at the clinic on another day.

She did some therapy. The therapy involved using a bike and using machines. That was ordered by a different doctor.

The Petitioner chose another treating doctor named Dr. Villasenior.

Villasenior sent her for an MRI and gave her pills.

She did not recall when she had the MRI.

Dr. Villasenior gave her an order to return to work on February 7, 2011. He gave her the order on January 5, 2011. The petitioner testified that the Company did not want her to return to work because she could not perform all her regular duties. She also admitted that the order was for a full duty release. She admitted that she did not return to work

She said Dr. Villasenior sent her to her therapy office on Pulaski Ave. She did not remember any other doctors.

The Petitioner went to a female doctor called Tara Sakavich. She did not remember who sent her to Dr. Tara Sakavich. She thought her son had searched and found Dr. Sakavich but was not sure.

The Petitioner's last visit with Dr. Sakevich was on October 12, 2011. The Petitioner admitted that Dr. Sakevich showed her an ultrasound of her foot. The.

The Petitioner said she began to see Dr. Sakavich in February of 2011. Dr. Sakavich made her wear a boot. At that time the Petitioner was not doing the physical therapy. The Petitioner said the boot gave her strength. She has not had any other treatment from Sakavich.

Then she had physical therapy.

The Petitioner was questioned about Petitioner's Exhibit No. 8, the records of Chicago Pain Center. The Petitioner testified that she did not recognize the name of the clinic but testified that she was seen

at a clinic on Pulaski. A questionnaire was filled out and the Petitioner admitted she signed the questionnaire. The questionnaire stated "I stepped on a piece of cardboard box and I slipped. That is when my foot slipped to the side." The Petitioner testified that she did not write this herself. She did not know who wrote it.

The Petitioner admitted she retired on October 27, 2013. She admitted that she receives a pension from the Union. She testified she receives approximately $1,500 a month. She did not know when she started receiving her pension benefits.

The Arbitrator finds the petitioner's testimony that she had stepped on a piece of cardboard not to be credible because this is not mentioned in the petitioner's history at Concentra on the evening of the occurrence, and because of her statements to Angela Hackett being inconsistent with her testimony.

(2) **RESPONDENT'S WITNESS ANGELA HACKETT'S TESTIMONY**

As of November 2, 2010 the Respondent's witness was known as Angela Flowers. Her name has changed due to marriage. She testified that her present occupation is Production Supervisor at the Company. Her occupation on November 2, 2010 was the same. She testified that she has been a Production Supervisor for twenty years. As of November 2, 2010 she had been a production supervisor for approximately thirteen years.

Ms. Hackett testified that she knew the Petitioner. She knew the Petitioner for thirteen years before the alleged date of injury of November 2, 2010.

Ms. Hackett communicated with the Petitioner in English regarding work instructions. The Petitioner responded to the work instructions by performing tasks. Ms. Hackett conversed with the Petitioner in English at times prior to November 2, 2010.

On the date of the alleged occurrence of November 2, 2010, Ms. Hackett had seen the Petitioner from time to time. They were working the second shift. The Petitioner and her co-workers would report to work at 3:25 p.m. and work until 11:55 p.m. Ms. Hackett saw the Petitioner from time to time throughout the shift. Ms. Hackett testified that she directed the Petitioner to work on the box forming machines because there wasn't any product to be processed on the Petitioner's usual machine.

At approximately 10:00 p.m., Ms. Hackett had a conversation with the Petitioner. Ms. Hackett encountered the Petitioner in the hallway between the back line and the table. Ms. Hackett noticed that the Petitioner could hardly walk. Ms. Hackett asked the Petitioner what happened. The Petitioner reported "me, twisty, twisty," and made a twisting gesture with her hands. Ms. Hackett asked the Petitioner if she slipped or fell. The Petitioner reported she did not slip or fall, but her ankle twisted. Ms. Hackett had Stan Sadowski take the Petitioner to the front door of the plant, on a golf cart. Ms. Hackett saw Mr. Ortega, the mechanic, in the hallway and asked him to interpret for the Petitioner. Ms. Hackett asked Mr. Ortega to ask the Petitioner whether or not she slipped on something. The answer was that she did not. Ms. Hackett asked if the Petitioner fell and the answ through Ortega was no. Ms. Hackett asked if the Petitioner had stepped with her foot in a crack and the answer through Ortega was no.

This conversation occurred at approximately 10:00 p.m.

Lunch would have been at approximately 8:00 p.m.

Ms. Hackett had observed where the Petitioner had been working earlier in the shift. She was working at the box forming machine. The Petitioner worked at the end of the machine stacking boxes. There was a debris cart for misshapen or broken boxes to be placed in. The Petitioner was stacking the well-formed boxes on a box cart. The machine was operating fine. There was no debris on the floor.

After Ms. Hackett sent the Petitioner to the clinic, Ms. Hackett returned to the area where the Petitioner had been working and there was nothing on the floor. It was clean. She asked the mechanic who had been operating the machine whether there were any malfunctions and he said no. She asked the mechanic whether the Petitioner fell or slipped on anything and the mechanic said she did not. Ms. Hackett asked the other works on the other machine the same questions and they indicated that they had not seen anything.

The Petitioner returned to the clinic at the end of the shift to turn in paperwork. Ms. Hackett encountered the Petitioner and asked her how she was. The Petitioner stated she was "ok, so-so."

Ms. Hackett saw the Petitioner on November 19, 2010 at 2:30 p.m. The Petitioner was entering the building. They had a conversation in English. Ms. Hackett asked the Petitioner how she was. The Petitioner then asked Ms. Hackett if she remembered that she told her that she slipped on cardboard. Ms. Hackett said that the Petitioner did not tell her that. Ms Hackett said she had told the petitioner that she asked her whether she slipped on anything and the petitioner had said no.

Ms. Hackett testified that she had written notes of the events of November 2, 2010 and the conversation of November 19, 2010. These were included as Respondent's Exhibit No. 3. She wanted to make her notes accurate.

On cross-examination by Petitioner's attorney, Ms. Hackett testified that she had some conversations with the Petitioner which were not related to work and were in English.

Ms. Hackett testified that she supervised approximately 30 employees on the second shift. There were seven work stations. The Petitioner's regular station was 700 bulk box station. That machine was down because of a lack of material. The Petitioner was working on a different box forming machine on the date of the alleged accident. The Petitioner was approximately 20 to 30 feet away from the machine when Ms. Hackett noticed the Petitioner had a difficult time walking. Ms. Hackett walked around the machine between four and five times before 10:00 p.m. It was her normal duty to walk around the production area and watch how the work is being done. The length of time between when the saw the Petitioner working and when she observed her limping was approximately a half an hour. Therefore if the Petitioner twisted her foot it would have occurred sometime between 9:00 p.m. and 10:00 p.m. In the conversation between the Petitioner and Ms. Hackett, the Petitioner stated "me walking, twisty, twisty." Ms. Hackett requested the assistance of Mr. Ortega to interpret. She asked the Petitioner whether she slipped, fell or tripped and each time the Petitioner reported she had not.

Ms Hackett had prepared contemporaneous notes, Respondent's Exhibit No. 3.

The Arbitrator finds Ms Hackett's testimony to be persuasive. She had diligently asked the petitioner if she had stepped on something or slipped on something and the petitioner had denied any such event at the time. The Petitioner asked Ms Hackett to change to a different version of the facts 17 days after the event.

(3) <u>DR GEORGE HOLMES' TESTIMONY Resp. Ex. 4.</u>

(a) **CREDENTIALS**

Dr. Holmes is a board certified orthopedic surgeon. He has been licensed to practice in Illinois since 1992. He concentrates in treatment of the foot and ankle. Resp. Ex 4 page 5.

He has been affiliated with Midwest Orthopedics at Rush since 1992. Resp. Ex. 4 page 5.

(B) EXAMINATION OF ANGELINA CAHUE

Dr Holmes examined Ms. Cahue on March 21, 2012. He took a history through a translator, Carmen Kenny, but Dr. Holmes said he also understands Spanish himself. Resp. Ex. 4 page 8.

The Petitioner gave him the history that she stepped on cardboard. Three sides of the cardboard were folded upward. She said she twisted her ankle. Resp. Ex. 4 page 9.

She gave a past history of no hospitalizations. Resp. Ex. 4 page 9

(c) RECORDS REVIEW

Dr. Holmes reviewed records from Concentra. The records of November 2, 2010 showed the Petitioner presented with right leg pain. She was saying that she had been walking and twisted her right ankle. Observations include no deformity, no redness, a full range of motion, normal capillary circulation. The pulses were intact. Sensation was intact. Resp. Ex. 4 page 10.

(d) PHYSICAL EXAMINATION

Dr. Holmes performed a physical examination. The ankle was stable. The drawer test for stability was normal. The pain was in the anterior-medial aspect of the foot. In other words, in front of the ankle but more towards the instep. It was a specific spot of pain. There was no edema, no swelling. The nerves were normal. There was no numbness. There was no tinel sign. The circulation was normal. The pulses were good. Resp. Ex 4 page 12.

(e) X-RAYS

X-rays showed medial ankle arthritis. She has joint space narrowing on the medial side of the ankle.

The x-rays showed the arthritis is exactly in the area where she has the pain. Resp. Ex 4 page 14.

Dr. Holmes reviewed an MRI study of January 27, 2011. This demonstrates significant arthritic change in the joint between the tibia and the talus. Resp Ex 4 page 14,

(f) DIAGNOSIS

Dr. Holmes opined that the diagnosis was arthritis of the ankle in the tibial-talar joint and also the hind foot. The November 2, 2010 injury was a minor sprain. Resp. Ex 4 pages 15-16.

Dr. Holmes opined that the accident of November 2, 2010 would not cause nor aggravate the arthritis. The arthritis is of a character that would have taken years or decades to develop. Resp. Ex 4 page 17. The force involved in the occurrence of November 2, 2010 would not have aggravated the arthritis because the force involved was minimal. Resp. Ex. 4 pages 18, 43. Dr. Holmes explained that the force involved was minimal because of the findings at Concentra that there was no deformity, no redness, and a full range of motion.

Dr. Holmes specifically disagreed with the finding of Dr. Sakevich that the Petitioner had posterior tibial tendonitis. That would be on the outside of the foot, not where the Petitioner had pain when Dr. Holmes saw her. Posterior tibial tendonitis would not have remitted if it had been present when Sakevich had seen the Petitioner. So Dr. Holmes disagreed with Sakevich's diagnosis. Resp. Ex 4 page 31-32.

Dr Holmes opined that the incident of November 2, 2010 did not involve enough force to aggravate the arthritis of the ankle or foot. Resp. Ex. 4 page 39.

(g) ABILITY TO WORK

With respect to the November 2, 2010 injury, the Petitioner was capable to return to work. That incident would not prevent her from continuing to work. That accident was not significant enough to require the petitioner to be held "off work," in the opinion of Dr. Holmes.Resp.Ex 4 page 18.

(h) MAXIMUM MEDICAL IMPROVEMENT

Dr. Holmes opined that the Petitioner had reached maximum medical improvement at the time of the examination or earlier. Resp. Ex. 4 page 19.

(i) PERMANENT PARTIAL DISABILITY

Dr. Holmes opined that there was no permanent impairment associated with the November 2, 2010 occurrence. Resp. Ex. 4, page 19.

(J) RECORDS REVIEW BY DR HOLMES

On March 5, 2014 Dr. Holmes reviewed additional records. There were 53 physical therapy visits from August 11, 2011 to May 18, 2012. Dr. Holmes expressed the opinion that these were not necessary nor reasonable to cure or relieve the examinee Cahue of any injury on November 2, 2010. A few physical therapy visits can help someone with a sprained ankle, but 53 is beyond what would be reasonable. Physical therapy will not help an arthritic ankle. Resp. Ex. 4 page 21.

Dr. Holmes expressed the opinion that Dr. Charles Allen's treatment had not been necessary nor reasonable to cure or relieve the Petitioner of an occupational injury. Much of Dr. Allen's treatment was for a fungal infection that had no causal connection. The remainder of the treatment was repetitive. Resp. Ex 4 pages 22-23.

The Arbitrator relies on Dr Holmes for the conclusion that the Petitioner had a minor sprain of the ankle and no other injuries

(4) MEDICAL RECORDS

(a) Concentra Pet. Ex. B

Concentra recorded on November 2, 2010 the petitioner was treated for what was considered to be an ankle sprain. She was treated with ice and later with heat, elevation, restrictions on activities, Motrin and physical therapy three times a week for two weeks. She was also given an Ace wrap and used cane and crutches.

Her next visit is November 4, 2010. The patient reported the condition was stable. The right ankle had minimal swelling. The ankle was painful to palpation. There was some decreased in motion in all the different planes. The patient should be limited to sitting 90% of the time and to avoid climbing stairs and ladders. The patient was seen on November 11, 2010. She felt the pattern of symptoms was no better. She had been working with light duty. She reported no improvement. She was tender over the medial malleolus. She was advised to use ice and hot packs, restrictions on activity and Motrin. She was to start physical therapy and to be sitting about 90% of the time. On November 18, the petitioner was no better, she was working with light restrictions, she was still taking the medications, still tender and limping. Again on November 24, 2010 the petitioner was seen. She reported she had not been working because light duty was not available. The pattern of symptoms was no better. The pain was described as moderate but persistent. The pain is exacerbated by walking.

The ankle showed no deformity. There was no tenderness over the base of the fifth metatarsal. There was no erythema, no redness, no instability. The assessment was right ankle sprain. She was to be sitting 90% of the time and to limit squatting and kneeling and to limit climbing stairs and ladders.

On December 1, 2010, the patient reported no change and was not working because there was no light duty available according to her statement. The right ankle showed no deformity, no tenderness over the fifth metatarsal, no bruising, no redness, no instability, plantar flexion was painful. The patient walks with a slight limp. The assessment was ankle sprain.

(b) Dr Villasenior Pet. Ex. C

Dr. Villasenor's records indicate that he first saw the Petitioner related to this claim, on December 2, 2010. At that time, the Petitioner gave a history of developing right ankle pain "when she was helping a co-worker move cardboard boxes." That history is different than the history we received from the Company which indicated that the Petitioner was walking in the area of the bank line and twisted her right ankle. According to the accident report completed by Nancy Trejo, the Petitioner did not trip, slip or step on anything.

Dr. Villasenor examined the Petitioner on December 2, 2010 and reviewed a June 2009 bone density study. As a result, it was Dr. Villasenor's diagnosis that the Petitioner had "ankle pain."

He re-examined the Petitioner on January 5, 2011. By then, the Petitioner had swelling in the right ankle and tenderness and Dr. Villasenor recommended an MRI of the right ankle.

The January 27, 2011 MRI of the Petitioner's right foot revealed significant osteoarthritis involving the talar joints, diffuse swelling to the distal central tibial epiphysis, chronic sprains of the anterior and posterior talofibular ligaments, tenosynovitis, fluid throughout the sinus tarsi and chronic proximal plantar fascitis and small ankle joint effusion.

Dr Villasenior referred the petitioner to Dr Sakevich

(c) Dr Sakevich Pet. Ex. D

In the Dr. Sakevich records of February 8, 2011, it says that this is a 66 year old female who twisted her ankle on November 2 on the right side, she did not feel this was a problem so she continued walking on it and working. She works in inventory in Tootsie Roll. She said it became worse and worse. It continued to swell and she had been resting, icing and found it was difficult to get around. She had her son present to translate. Dr. Sakevich found that the muscle strength was 5/5. There was positive pain at the distal tibia on the right. The pain was at the posterior tibia. Tenderness especially below the malleolus and coursing proximal to the right side. She had no pain in the ligament. No pain in the insertion to the plantar fascia. No pain in the mid foot.

There was a sinus tarsi syndrome seen on the right and chronic plantar fasciitis on the right. Dr. Sakevich concluded that the patient was most symptomatic on the examination of the posterior tibia tear on the right side and distal tibia. She recommended an AFO Arizona brace and she wanted X-Rays of the foot also. The X-rays were those at Christ Hospital described above. On March 23, 2011, Dr. Sakevich saw the petitioner again. She was given the prescription to go back to a brace maker and have the Arizona style brace made. It had not been done. She was not to work until the brace was made. She was to use the CAM walker until the Arizona brace was made. Then she would be able to return to work.

On March 30, 2011, she did have the brace and it had been made correctly. It helped her with stability but did not fit well into her shoes. The direction was to go to New Balance and get properly fitting shoes. She was allowed to return to work on Monday with restrictions to see if she had pain or discomfort. Dr. Sakevich was to see the patient back in 3-4 weeks to see how she was doing with her proper fitting shoes and brace. On May 7, 2011, Dr. Sakevich saw the petitioner. She said she was doing a lot of work around the house, up and down stairs and cleaning and then does not feel better. She does not wear the AFO brace every day. Often times, she does not put it on until she becomes sore or is doing more activity.

A complete ultrasound was performed which showed tenosynovitis especially at the insertion of the tarsal navicular.

The assessment was posterior tibial tendonitis with tearing on the right and a subchondral defect on the right.

Dr. Sakevich thought the petitioner was doing too much ambulation and not using the brace and the tenderness was due to continuing strain. She wanted to put a below the knee cast on the petitioner and the petitioner agreed.

On May 25, 2011the petitioner still had pain in the cast. She did a lot of walking in the cast, according to the son. The pain was still not as bad as it had been. Dr. Sakevich recommended that the petitioner needed to be in another below the knee cast. She was not complying with the resting and rest would be necessary to insure that she heels correctly. Dr. Sakevich explained that it would be necessary to put her in a cast or she would not heal. The entire time the doctor had been trying to keep her off of her foot, and she still doing a lot of activities even at home. A cast was again applied. They discussed the risks of phlebitis. On June 7, 2011 the petitioner was seen again. She stated she is still not resting, she continued to water her grass, gardening, cleaning bathrooms, up and down stairs, just won't stay still even though she is off of work. She felt the cast was tight but she came in with a very worn down and flattened on the plantar surface from the ambulation. The physical examination showed positive to pain on palpation of the posterior tibial tendon. There was positive pain on palpation of the distal tibia on the right. No pain to palpation on the FT ligament.

The doctor discussed the ultra sound. She discussed frankly that she could place her in an AFO but she is so active that she would still do the amount of activity that she currently performed which was too much and continued to cause delay in healing. She was again put in a below knee cast. She was given warnings about phlebitis. On July 1, 2011 another doctor by the name of Dr. Lind saw the petitioner in place of Dr. Sakevich. The son said that his mother does not stay off of her feet. She continues to exert herself at home, gardening, cleaning, cooking, up and down the stairs even though she is off work. The patient was complaining about her cast being uncomfortable. The examination showed positive pain on palpation to the tibialis posterior tendon on the right especially inferior. There is pain on palpation at the anterior aspect. The ultra sound was performed again. It showed acute tibialis posterior tendonitis. The decision was to repeat the MRI.

The MRI report of July 11, 2011 showed soft tissue swelling within the ankle, bone marrow edema, moderate effusion in the tibial talar joint. Mild tenosynovitis of the posterior tibial tendon, no acute tears although there is some mild attenuation of the tendon. No abnormal effusion. Evidence of a longitudinal split or tear within the peroneus brevis tendon. The tear is 1.8 centimeters. Likely sinus tarsi syndrome on the right. Significant arthropathy of the subtalar joints. Evidence of tendonitis of the distal tibial tendon, no tears.

Dr. Sakevich saw the petitioner again on July 30, 2011. She reviewed the MRI and thought it showed the petitioner was improved. The tear of the peroneus brevis tendon was not symptomatic. She recommended the patient be in the AFO and a prescription for physical therapy. A work note was given for her to remain off work. The patient relates that she feels better and only the tibia hurt. She was again advised to order the CAM walker or AFO brace until she starts therapy.

On August 20, 2011 there was another visit. She was to wear an AFO and continue with therapy.

She was seen on September 14, 2011. She was again to continue wearing the AFO brace and continue physical therapy. She was given a note to work four hours per day. On September 28 she had not been wearing the AFO brace, but she had been doing the physical therapy. If she wears the brace, she has no pain. If she does not wear the brace, she has pain after 25 minutes of walking. The ultra sound on that day revealed acute tibialis anterior tendonitis. The tendon appears to be inflamed with no evidence of a longitudinal tear. The tendons of the peroneus brevis and all other tendons were unremarkable. She apparently said the job would not allow her to work four hours per day or work with a brace. On September 28, 2011, petitioner returned for follow up for her tendonitis on the right and contusion. She had not been wearing the AFO, she had been doing the physical therapy. The ultra sound was discussed and the petitioner was to return to work and return to the clinic in two weeks.

On October 12, 2011, the petitioner said her job would not let her work with an AFO, four hours per day, or light duty. She said she feels improved but not good enough to return to work all day. She is here with a different son. She was advised to wear the AFO brace but she came to the office without it. She states she only wears it in the house, not outside.

The complaints were pain on ambulation. The ultra sound was performed. It revealed no inflammation of the tibialis anterior tendon. The tendon has no evidence of a longitudinal tear. The impression was tibialis anterior normal right ankle. The ultra sound was reviewed. It showed no pathology. The patient stated she still has pain in the tibial and feels unstable when standing. This other son said that his brother had been exaggerating the non-compliance and the petitioner stated she was compliant although the doctor pointed out she did not even bring the brace today going to the office. Dr. Sakevich said that she had exhausted all the treatments. The patient was advised to get a another opinion. She was given an off work slip for two weeks and ordered to seek a second opinion. This was the last visit to Dr Sakevich, on October 12, 2011.

(d) Preferred MRI Pet Ex. E

An MRI showed osteoarthritis involving the tibial/talar joint, subtalar joint in her hind foot and mid foot articulations. There is diffuse bone marrow edema. Dr. Sakevich wrote it was apparently post-traumatic. There was an osteochondral defect in the talar dome. There was a sprain of the ATF and posterior fibular ligaments

(e) Chicago Pain Center Pet. Ex A

The petitioner attended many physical therapy sessions, with no apparent benefit according to these records.

CONCLUSIONS OF LAW

ON THE ISSUE "C" WHETHER THE PETITIONER HAD AN ACCIDENTAL INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT OF THE ARBITRATOR FINDS:

The Petitioner did not establish that her accident arose out of the employment. The Petitioner did not establish that there was a hazard associated with the employment that caused or contributed to the injury. In the explanation provided to the supervisor Ms Hackett on the evening of the occurrence the petitioner indicated, "me, twisty, twisty" and through the interpreter Ortega, Ms Hackett asked if the petitioner had stepped on anything or slipped on anything and the petitioner said no. Ms Hackett looked at the area where the petitioner had been working and there was no cardboard on the floor. Dr Holmes testimony is persuasive that there was not any serious injury to the ankle sustained, the petitioner had just a minor strain.

The Arbitrator relies on the precedent case of Cathy Baldwin v. Illinois Workers' Compensation Commission, 409 Ill.App.3d472, 494 N.E.2d 1151, 351 Ill.Dec. 56 and First Cash Financial Services v. Industrial Commission, 367 Ill.App. 3d 102 853 N.E.2d 799, 304 Ill.Dec. 722 and Lourdes Oliver v. Posen-Robbins School District No. 143.5, 13 IWCC 297and Kulas v Sherman Hospital, 15 IWCC 329, 2015 WL 4082660, 11 IWCC 35656.

In the Baldwin case, the Appellate Court stated that in order to determine whether a claimant's injury arose out of her employment, the court must first categorize the risk to what she was exposed. Risks to employees fall in the three groups

(1) Risks distinctly associated with the employment;
(2) Risks personal to the employee such as idiopathic falls;
(3) Neutral risks that have no particular employment or personal characteristics

In the Baldwin case, the Petitioner was in good health and had no condition that affected her balance or made her dizzy and had no problems walking or using the stairs. In the course of her work, she slipped and fell while she was descending a staircase. The claimant Baldwin testified she did not know what caused her to slip. The claimant Baldwin's testimony eliminated any notion that the fall was idiopathic. As to whether the fall stemmed from a risk associated with employment, the claimant Baldwin theorized that moisture might have built up on her shoes walking through a freezer but her testimony was pure speculation. The claimant Baldwin did not show more than a mere possibility that moisture which might have built up on her shoes when walking

through a freezer and caused her to slip and fall on the stairs. In sum, the claimant Baldwin did not know what caused her to fall on October 8, 2006.

For Ms. Baldwin's injury caused by unexplained fall to arise out of the employment the claimant must have presented evidence which supports a reasonable inference that the fall stemmed from a hazard related to the employment. However, an injury resulting from a neutral risk to which the general public is equally exposed does not arise out of the employment. By itself, the act of walking up or down a staircase does not expose the employee to risk greater than that faced by the general public. Because claimant Baldwin did not present any evidence of a cause of her fall on October 8, 2006 or that she was exposed to risk greater than that faced by the general public, she failed to prove her injury on that date arose out of her employment. The Commission's decision denying her any benefits was not against the manifest weight of the evidence and was sustained.

In this case of Ms Cahue, like Baldwin, the petitioner was walking within the plant premises and twisted her ankle. The risk is a neutral risk. The petitioner has not established that any hazard associated with the employment increased her risk of twisting her ankle.

This case is not similar to the precedent William G. Ceas and Company v. The Industrial Commission, 261 Ill. App. 3d 630, 633NE2d 994, 199 Ill.Dec 198. In the Ceas case the employee fell while going down a flight of stairs; she was rushing to put a packet into a Federal Express box. The hazard associated within employment was the rushing required to put the packet into the FedEx box on time.

This case is not similar to the precedent Chicago Tribune Company v. Industrial Commission 136 Ill. App. 3d 260, 483NE2d 327, 91 Ill. Dec. 45 (1985). In that case the Commission inferred that the Petitioner had slipped on water that had been tracked into the employer's building.

Therefore all claims for compensation benefits are denied.

Dated and Entered

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Janina Toczek,
Petitioner,

18IWCC0130

vs.

NO: 15 WC 8206

ABM Janitorial Services,
Respondent.

DECISION AND OPINION ON REVIEW

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

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.

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

DATED: MAR 6 - 2018
o3/1/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0130

TOCZEK, JANINA
Employee/Petitioner

Case# **15WC008206**

ABM JANITORIAL SERVICES
Employer/Respondent

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:

2291 BELLAS & WACHOWSKI
PETER C WACHOWSKI
15 N NORTHWEST HWY
PARK RIDGE, IL 60068

2999 LITCHFIELD CAVO LLP
ANITA S JOHNSON
303 W MADISON ST SUITE 300
CHICAGO, IL 60601

18IWCC0130

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

JANINA TOCZEK
Employee/Petitioner
v.

Case # **15** WC **008206**

ABM JANITORIAL SERVICES
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David A. Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **July 26, 2016, August 30, 2016, December 19, 2016, January 26, 2017 and February 28, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

On11/26/2014, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$30,795.44**; the average weekly wage was $592.22.

On the date of accident, Petitioner was **57** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

PETITIONER FAILED TO PROVE SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT ON NOVEMBER 26, 2014.

THEREFORE, ALL OTHER ISSUES ARE RENDERED MOOT.

COMPENSATION IS HEREBY DENIED.

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

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

David A. Kane
Signature of Arbitrator

March 7, 2017
Date

MAR 8 - 2017

Janina Toczek v. ABM Janitorial
Court No. 15WC 8206

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On Wednesday, November 26, 2014, the day before the Thanksgiving holiday, the petitioner, in the course of her activity of collecting garbage, claims an acute injury to her low back, although it was reported for the first time on December 22, 2015. (Arbitration Transcript July 21, 2016, Janina Toczek, pp. 179-180 and Arbitration Transcript December 19, 2016, Maria Saldana, pp. 58-61).

According to the testimony of all witnesses, Agata Gazda, Maria Saldana and the petitioner herself, her job duties are described and scheduled as follows. (Arbitration Transcript July 26, 2016, Agata Gazda, pp. 21-22; Arbitration Transcript December 19, 2016, Maria Saldana, pp. 15-18 and Arbitration Transcript July 21, 2016, Janina Toczek, pp. 172-174). At the time of the alleged injury, 10:30 p.m., petitioner was working on Floor 31 which contains a library, some private offices around a secretarial area, a kitchen and two bathrooms. The tenant here is the law firm of Sidley. The petitioner's job duties included collecting garbage, vacuuming, mopping, cleaning bathrooms and kitchen areas on this floor. Because the tenant was a law firm and they would frequently work late, vacuuming and cleaning the kitchen and bathroom areas were left to the last. Otherwise there would be complaints when the tenants return to work the next day that these areas were not properly cleaned. Therefore, garbage collection occurred first on any floor of the tenant Sidley, including the floors to which the petitioner was assigned. Garbage collection would

be over by 9:00 or 10:00 as the men who collected the barrels of garbage from the freight elevator lobbies transported them down to the dock area at 10:30. There may be a final sweep or an extra pick-up if heavy gondolas had been requested or were, in fact, on the various floors. The petitioner reports a different order of performing these duties, contrary to the schedule, because she is alleging the incident occurred at 10:30 and involved garbage collection. (Arbitration Transcript August 30, 2016, Janina Toczek, pp. 22-24).

At the time of the incident, the petitioner was engaged in the activity of emptying recyclable garbage from a bin (containers used by the tenants for waste) into barrels (the collection of said waste for transportation for disposal). See Respondent's Exhibits 1a, 1b, 1c and 1d. According to petitioner's testimony, she bent to pick up a container of fifteen inches in height by bending her knees and flexing forward at the waist. This container had a weight estimated by petitioner of 20 to 24 kilos or 44 to 53 pounds. (Arbitration Transcript July 20, 2016, Janina Toczek, pp. 180, 186; Arbitration Transcript August 30, 2016, Janina Toczek, pp. 38-50 and Respondent's 1c). She bent at the knees and forward flexed immediately feeling a sensation in her lower back. (Arbitration Transcript July 20, 2016, Janina Toczek, p. 186 and Arbitration Transcript, August 30, 2016, Janina Toczek, pp. 50-53; Dr. Sokolowski office visit note of April 3, 2015). She lifted and took two steps to lean the bin on the edge of the barrels (Respondent's 1b which was 36 inches in height) and turned the heavy load upside down. (Arbitration Transcript August 30, 2016, Janina Toczek, p. 31). The arbitrator observes that the petitioner is 5' 2" tall and described raising the bin to neck height in the air and flexing backwards, before turning the bin over to dump the contents in the barrel.

Petitioner reported to the Section 12 examiner, Dr. Ghanayem, that she was performing this activity at waist level when she felt the pain in her back. (Dr. Ghanayem Deposition Transcript of March 23, 2016, pp. 2-3). In addition, on her first visit to her Polish speaking physician, Dr. Sokolowski, (which contains the only description in the medical records of the accident itself) on April 3, 2015 she clearly stated "as she bent to pick up the unexpectedly heavy recycling bin, she experienced a sharp pain in her back".

There was a system in place as testified to by all witnesses, including the petitioner, wherein on feeling a heavy weight, the container could be left for pick-up by the male collection crew or emptied book by book into the barrels. (Arbitration Transcript July 21, 2016, Agata Gazda, pp. 94-95 and 100-124; Arbitration Transcript July 21, 2016, Maria Saldana, pp. 160-168 and Arbitration Transcript December 19, 2016, Maria Saldana, pp. 27-31; Arbitration Transcript August 30, 2016, Janina Toczek, pp. 55-56). If the container was that heavy, it would not be lifted in the air, but would be noted immediately upon attempting to raise the same from the ground, while her back was in a flexed position and lowered to the ground. (Arbitration Testimony July 21, 2016, Agata Gazda pp. 94-95 and December 19, 2016, Maria Saldana, pp. 29-30).

The testimony and demonstration of Agata Gazda as to dumping bins into the barrels was based on the bin identified in 1a measuring thirty inches in height and although stipulated to by the petitioner's attorney was, in fact, not the container to which petitioner testified. (Arbitration Transcript July 21, 2016, Agata Gazda, pp. 84-98). Further, this individual neither witnessed the incident nor was a representative of the company to whom

the accident should have been reported but merely a co-worker and union steward. (Arbitration Transcript July 21, 2016, Agata Gazda, pp. 191-21).

Maria Saldana, the night supervisor for One South Dearborn at the time of the accident, had been working for ABM in that capacity for an extensive time period. During that time, she entered as a cleaner and still occasionally performed that work in the event of short staffing. (Arbitration Transcript December 19, 2016, Maria Saldana, pp. 6-8). Her duties as supervisor include taking attendance which involves being present for the employees to punch or clock in and out at the beginning and end of the shift (ten minutes to 5:00 p.m. and ten minutes to 1:00 a.m.) so that payroll can be properly ordered and all of the work is covered. If an employee does not punch in, she fills in that employee's work position. Therefore, it is credible that she would be present as the employees punched in and out and observe them and converse with them on a daily basis. Her testimony that she saw the petitioner on the Wednesday before the Thanksgiving holiday and wished her a Happy Thanksgiving as she did with all the employees in line is credible. If the petitioner did not respond in kind and Maria could not understand her comments, she would have called Agata Gazda to translate. Her testimony is credible that she observed nothing unusual with regard to the petitioner at that time. (Trial Testimony December 19, 2016, pp. 10-11; Trial Testimony July 21, 2016, pp. 32-39).

Although petitioner claims an immediate onset of low back pain radiating bilaterally into both legs, (Arbitration Transcript July 20, 2016, Janina Toczek, pp. 186, 187), it should be noted that the petitioner did not seek medical attention until December 8, 2016 when she went to the emergency room at Christ Advocate Hospital. The records clearly indicate that she was seen with a chief complaint of neck radiating to bilateral lower

extremity pain **associated with nausea and vomiting**. While her son accompanied her to translate, it is clear that her admission was not solely for complaints of low back pain.

Petitioner, Agata Gazda and Maria Saldana all testified to the same accident/absence reporting procedure under which the petitioner would report the accident to Maria Saldana in person or via telephone contact (in the latter circumstance by her English speaking son). The procedure for reporting an absence is for the employee to come in and see Ms. Saldana if they are at work. (Arbitration Transcript December 19, 2016, Maria Saldana, p. 36).

If it is a work accident, Ms. Saldana takes down the information. If the individual needs a translator, such as the petitioner, Agata Gazda would be called to help. Next Maria Saldana calls the nurse line. After the nurse line is called, Ms. Saldana gives them the information regarding the accident and then turns the phone over to the injured worker after she advises them if a translator is needed. After the report to the nurse line is completed by the injured worker and herself, she makes out the injury report which is a Form 45 and any accompanying notes she has about the incident. (Id. 38-39).

If it is not a work accident, Ms. Saldana fills out a leave of absence form as in Exhibits 2a through 2e and forwards it to the Human Resources Department. (Id. 36-38).

If the individual requires an absence and is not at work, they are allowed three to five days calling in periodically. (Id. 38). After that, supporting documentation from a doctor must be received. In this case, as with her prior absences, the petitioner's son would bring in an "off-work slip" or release from work by the doctor. Maria Saldana would take that

document, fill out a leave of absence form, putting in the doctor's comments as well as what she was told as the reasons for the absence on the top part of the form. It would then be sent to Human Resources, along with the doctor's note, where individuals there would grant the leave or extend the leave, sometimes scratching out the leave request period entered by Maria. In the case at hand, this activity is reflected in Exhibits 2a through 2e. (Id. 49-56 and Dr. Shah's records, Respondent's No. 6).

Petitioner's illness December 1, 2016 through December 22, 2016 was communicated to Maria Saldana by her son who cited stomach problems and did not report an injury until the December 22, 2016 telephone conversation with Maria Saldana. (Id. 46-56). According to Dr. Shah, who treated her at the emergency room and for a period of time thereafter, she was admitted to the hospital for vomiting and lower back pain. (Dr. Shah's office visit of December 11, 2014).

The arbitrator finds the petitioner's testimony that she reported this problem to Maria Saldana when petitioner saw her as she punched out from work is not credible. The testimony of her subsequent alleged reports of the incident, as well as that of her son, are conflicting and also not credible with regard to the manner and details of reporting her past and present absences. (Arbitration Transcript July 21, 2016, Janina Toczek, pp. 195-196; Arbitration Transcript August 30, 2016, petitioner's son, Krzysztof Toczek, pp. 5-6, 74-75, Krzysztof Toczek, 132-140). All treating records are devoid of any history other than that to Dr. Sokolowski on her initial visit with him on April 3, 2015 described above.

Petitioner's son testified that he never spoke with Maria Saldana until after the incident in question which categorically was contradicted by petitioner's and Maria Saldana's testimony that he would deliver off-duty

slips from her treating doctors in the past for non-work related problems as he did after this incident. Petitioner's testimony denying ever having seen, filled out or provided information for respondent's Exhibit No. 2, the ACE/ESIS report of injury form dated January 10, 2015, was also completely contradicted by her son's testimony that he filled out all of the information contained on that five page document, including the dates and signing for his mother, the petitioner. In addition, all of the information contained thereon was, according to this witness, obtained from his mother. Petitioner testified, in addition to reporting her back injury as she punched out on the day of the accident, she telephoned the same into the Human Resource Department on an unknown date speaking to an unknown individual in Polish.

Maria Saldana, the petitioner's supervisor, was in constant contact with the petitioner's son receiving the doctor's releases from work after the three to five day period allowed by Human Resources before such paperwork was required. She advised the petitioner's son on December 8th, that doctors' releases would now be needed. It was after that, the petitioner was seen at the emergency room at Advocate Medical Center. (Arbitration Transcript December 19, 2016, Maria Saldana, pp. 44; Christ Hospital records).

Respondent's witness, Maria Saldana, began receiving, through petitioner's son's visits to the workplace, the off work notes from Dr. Shah. She then made out the proper leave of absence forms beginning upon receipt of Dr. Shah's documentation of December 11, 2014. (Respondent's Exhibits 2a and 2c). On December 22, 2011, Ms. Saldana received the first potential notice of an accident when the petitioner's son, in a telephone conversation with her, stated that there were insurance coverage problems

because no "incident report" had been made out. At that point, Ms. Saldana questioned the petitioner's son about an accident and advised him of the need for contact with the Human Resources Department to report the same. (Arbitration Transcript August 30, 2016, Krzysztof Toczek, p. 107; Arbitration Transcript December 19, 2016, Maria Saldana, pp. 47-51). In respondent's Exhibits 3 and 4, Ms. Saldana memorialized her conversation with the petitioner's son and previous conversations regarding petitioner's absences after the last work day before the Thanksgiving holiday. According to company policy, Ms. Saldana filled out the Form 45, Respondent's Exhibit No. 4, but had no information regarding an accident or the resultant injury and, therefore, those areas were blank. None of these documents outline the details of the accident nor the area of the body injured. Up until this time, there was no information about a work accident or a back injury received by respondent or communicated by petitioner. (Maria Saldana 12/19/16, pp. 50-66).

After her hospitalization, the physician who treated her there, Dr. Sunil Shah, continued to see the petitioner on a weekly to bi-monthly basis until the end of February, 2015 for a myriad of medical problems including her low back pain. (Office visit note Dr. Sunil Shah's records dated February 28, 2015). This visit was clearly for her general medical condition and ended in an assessment of unspecified GERD, dyslipidemia, unspecified hyperlipidemia, urinary tract infection and backache. The only treatment he prescribed at this time was continued use of Ibuprofen twice a day, as well as other medication for her other conditions. As in all of his notes, there is no report of a work accident. The releases from work provided by Dr. Shah and found in his records (Respondent's No. 6) and Respondent's Exhibits 2c-2d give a diagnosis only of "medical" and the

prognosis of "poor". Only on the second of these for the period of December 19 through January 6 is a diagnosis of low back pain found. This is the release that returned petitioner to work on January 7. Maria Saldana duly noted on her leave of absence forms the doctor's assessment and any information she received from the petitioner's son in requesting each period of leave. There is an absence of any indication of work accident and/or associated low back complaint. He saw her again April 2, 2015 when all of her conditions, work-related and otherwise, were reviewed as well as medications and she was to follow up in three months.

Petitioner instead transferred care beginning April 3, 2016 to Dr. Sokolowski, a Polish speaking physician. His records reveal that she was a "self-referral". He saw her and continues to see her on a monthly basis treating her with conservative medications, physical therapy, Ibuprofen and an orthosis, ultimately recommending epidural steroid injections to be followed by an ablation procedure, a TENS unit and he continued to recommend an FCE which he describes in a February office visit as a test that would "substantiate the need for further treatment including additional physical therapy **and/or** intervention directed at the spine". (Office Visit February 1, 2016).

Petitioner never requested restricted releases for work from her doctor and he never addressed the issue of light duty. Petitioner has not returned to work since the alleged date of accident through the present with the exception of January 7, 2015 when she was observed by Agata Gazda and Maria Saldana without any supportive devices, complaints of pain or unusual movements. Maria Saldana inspected petitioner's work the day of the alleged accident as well as January 7, 2015 and did not find that any

work had not been completed. (Arbitration Transcript December 19, 2016, Maria Saldana, pp. 79-80).

Since the accident, the petitioner testified to non-stop radiating pain down both legs into her feet at a pain level of 7. She testified the pain was worse on the date that she returned to work. During this time through the present, she has difficulty going up the six stairs to her house; she cannot bend forward or to her feet; she cannot turn over and does not use the washer or dryer down ten steps in her basement. She does not shop; she no longer maintains her garden; her son who is a chef (and provided the Thanksgiving dinner) cooks for her and the son who testified does housekeeping and laundry. (Arbitration Transcript July 21, 2016, Janina Toczek, pp. 214-220 and 222-229). She claims she gets medication from Dr. Sokolowski, which was not obtained through a pharmacy nor billed separately, by signing a paper at his office. (Arbitration Transcript August 30, 2016, Janina Toczek, p. 217).

Ms. Saldana saw the petitioner on the date of the accident over the lunch hour when the petitioner cleaned the second floor and at punch-out time. She had a conversation with the petitioner wishing her a Happy Thanksgiving as she did with all other employees in the line to punch out that night, to which they responded the same. Ms. Saldana did not note anything unusual during those times. Ms. Saldana inspected petitioner's work on November 26, 2014 and June 1, 2015 and found no deficiencies. Ms. Saldana does not recall anything unusual with regard to the quality of the petitioner's work or her movements, behavior or complaints on January 7, 2015 when she returned to work. (Arbitration Transcript December 19, 2016, Maria Saldana, pp. 79-80). Further, Maria Saldana saw the

petitioner on two later occasions. One in March of 2015 and one in March of 2016.

The occasion in March of 2015, was bringing flowers to a co-employee and close friend of the petitioner's, Maria Hannish. At that time, Ms. Saldana picked the petitioner up at her home, visited with her there, brought her to Maria Hannish's to deliver the flowers and returned her home again. As Ms. Saldana reached the petitioner's home, petitioner called her as she arrived, but was invited to go inside the house for refreshments. Ms. Saldana saw the petitioner come down the six stairs and come over to her car. It was wintery weather. The petitioner went up the stairs in front of Ms. Saldana. The petitioner made coffee and prepared to serve coffee and cake in the kitchen. Ms. Saldana and the petitioner's husband were seated on a couch behind a coffee table and the petitioner bent serving her coffee, tea and cake. They spent 45 minutes visiting with each other. Ms. Saldana saw the petitioner putting on her boots and coat and they traversed down the six stairs to Ms. Saldana's car. Petitioner got in and out of Ms. Saldana's small vehicle without event or comment. When they arrived at Ms. Hannish's residence, they had to park one and a half to two blocks away. They walked through the wintery weather together without incident to Maria Hannish's house. They spent approximately 45 minutes to an hour there visiting with Maria Hannish. They then walked the block and a half to two blocks to Maria Saldana's car and returned to the petitioner's home where she ascended the stairs. No supportive devices, facial grimaces, pain complaints or discussion of the injury was visible or were had during this entire period. (Arbitration Testimony December 19, 2016, Maria Saldana, pp. 83-91).

In March of 2016, Ms. Saldana attended the funeral mass of Maria Hannish and did not see the petitioner inside the church. However, she did see the petitioner outside by the hearse. She was dressed in two inch heels and stood the entire 45 minutes with a crowd that mingled and spoke with each other on the steps of the church. Ms. Saldana did not have occasion to talk to the petitioner on that date but did not observe any facial grimacing, pain, supportive devices or any indication that the petitioner was in pain. The petitioner did appear to be crying and grieving for her friend. (Arbitration Transcript December 19, 2016, Maria Saldana, pp. 91-95).

At no time on these two occasions did the petitioner offer to discuss the incident, her injury or any current complaints and behaved in a normal manner.

Dr. Ghanayem examined the petitioner on September 28, 2015 and reviewed medical records as supplied to him by respondent and marked in his deposition as Deposition Exhibit 2. Dr. Ghanayem opined that the petitioner's injury was soft tissue only with no permanent change in her underlying condition based on the following. (Deposition Transcript of Dr. Ghanayem, p. 44). The MRI scan of December 29, 2014, on his personal review, showed age appropriate degenerative changes consisting of a mild degree of stenosis at L4-5 which means some structural narrowing but non-compressive and no disc herniation. (Id. at 22-25). Stenosis is crowding of the cauda equine and indicates there is less space or room but it is still not compressive. (Id. at 25-26). The crowding or stenosis is caused by the degeneration. (Id. at 27).

A disc herniation is a tear of the annulus and the nuclear material and the nuclear material comes out. (Id. at 28-29). None of these are seen on the diagnostics.

A bulge is not a proper diagnosis. It is a descriptor. When the disc is a little narrower, the outer cover gets a little redundant or thicker, hence, the bulge that is seen on the MRI. (Id. at 29).

Petitioner's examination findings revealed a morbidly obese (5' 2" 160 pound) 60 year old female with "unusual" or non-anatomic findings and three positive Waddell signs as follows: tenderness from the base of her neck through the lumbar spine; pain in the low back on compression or pushing down on the individual's head while standing (Waddell Sign No. 1); truncal rotations with the knee while the spine is in a neutral position (Waddell Sign No. 2). The first set of findings is non-anatomical. There is no physiological explanation for these symptoms. In the case of the compression test and the truncal rotations with the knees, there is no load being placed on the spine and even if you had a disc herniation, that test should be negative whereas they were positive in the petitioner. (Id. at 14-16). The third Waddell sign was distraction through the shoulders that would be pulling on the shoulder joint capsule. Again, not loading the spine but tugging on the shoulders, her findings were positive which is non-organic and cannot be explained.

In examining her, she was able to backward and forward bend only ten degrees. However, when observed going from the chair to the exam table, she performed the full 45 degrees of flexion. (Id. pp. 17-18). Straight leg-raising caused back pain and, therefore, is negative because it should cause radiating pain. (Id. at p. 19).

Finally, the mechanism of the injury as described to Dr. Ghanayem and as found by the arbitrator above involved an individual in a bent over position working from the waist level down which puts more stress on the muscles and can cause a sprain to these core muscles.

On the other hand, in treating lumbar stenosis, the patient is treated in a flexion based physical therapy because this relieves the problem. In order to aggravate a pre-existing asymptomatic condition of lumbar stenosis, the back has to be in extension or hyper-extension position. Extension is bending backwards. Examples would be working on an overhead drop ceiling and bending backwards, resulting in leg pain. (Id. at 33). Finally, her complaints of tenderness from the cervical base to the lumbar base does not explain anatomically the radiating pain into the legs. That finding, the three Waddell signs and the x-ray finding, coupled with bending over and picking up something heavy, lead to a diagnosis of back sprain.

The doctor further opined that the suggested treatment of epidural steroid injections, advancing possibly to an ablation procedure are not appropriate when there is no neurologic compression as in this case. Epidural steroid injections operate on a theory of cutting down the inflammation due to the compression of the nerve. In this case, there is no compression. (Id. at 37-38).

As to ablation, the doctor questions the location of the ablation as it would be impossible to decipher because there is not a single level disease causing a defined pain distribution that coordinates with any type of anatomic physiology. (Id. at 37-39). In this case, the only reason to do an ablation with findings up and down the spine and non-organic examination findings would be to generate revenue. (Id. at 39-40).

The doctor further opined that she did not require any further treatment or diagnostics, no injections, FCE's, surgeries or ablations and recommended a return to work without restrictions and use of Ibuprofen. His diagnosis is back strain which resolved in a number of months from the

accident. (Id. at 41). Objectively, she could do her regular work activities. (Id. at 42).

This back sprain led to no permanent injury because the radiographic condition of degenerative spine changes is like "gray hair". It is just what you have. She is 58 years old with age appropriate degenerative changes, which is not a pathologic diagnosis. (Id. at 44-46).

At the petitioner's attorney's request, the doctor speculates as to the amount of lost time to cure the condition he diagnosed and places it between four and eight weeks. (Id. at 82-86). Because she had nothing on her examination, any FCE or injections are not needed. She had nothing but non-organic physical findings and nothing to substantiate any objective disease process. (Id. at 87).

Based on the above, and after considering the entire record, the Arbitrator finds that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment on November 26, 2014. The Arbitrator further finds that even if he found accident, he would find that there is no causal relationship between the alleged accident and Petitioner's present condition of ill-being.

Therefore, all other issues are rendered moot.

Compensation is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEMETRIUS TRIPLETT,

Petitioner,

18IWCC0131

vs.

NO: 08 WC 47109

RA SHAVITZ,

Respondent.

DECISION AND OPINION ON REMAND FROM THE APPELLATE COURT

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

Initially, a summary of the extensive history of this litigation is necessary. The case was arbitrated before Arbitrator Petersen pursuant to Section 19(b). The Arbitrator found Petitioner did not sustain his burden of proving that a stipulated accident caused his condition of ill-being. When he denied the claim, the Arbitrator noted Petitioner's testimony was patently incredible based on his testimony that he never had previous back pain and had not previously filed a workers' compensation claim even though he filed a workers' compensation claim in 2002 claiming injury to his low back. The Arbitrator also noted inconsistencies in his histories to medical providers and that Respondent's Section 12 medical examiner found exaggerated symptomology and positive Waddell signs. Therefore, Arbitrator found the opinion of the Respondent's Section 12 examiner more persuasive than that of Petitioner's treating physician. The Commission corrected a clerical error in the Decision of the Arbitrator but otherwise affirmed and adopted it, with one Commissioner dissenting.

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The Circuit Court reversed the Commission. The Court indicated that even though Petitioner did not relate his previous workers' compensation claim, "Respondent never asked any further questions of Triplett regarding the so-called back injury and its connection with Petitioner's condition of ill-being as a result of the accident. The Respondent never confronted Triplett with the Commission's record to explain the apparent inconsistency. The Court finds Respondent's impeachment of Triplett was improper as a matter of law. The Commission's credibility determination was in error. If on remand, the Commission confirms its finding on conflicting medical evidence, this Court will confirm the Commission's decision***."

On remand, the Commission issued a decision, signed by Commissioner Dauphin with Commissioners White and DeVriendt issuing *Ziegler* concurrences. In that decision it was noted "on December 1, 2010, the Circuit Court of Cook County entered its Decision reversing the Commission's Decision and remanding the case to the Commission with directions to enter an award for Petitioner in accordance with its Order." Thereafter, "after considering the entire record," the Commission found Petitioner proved causation and awarded medical expenses. However, the Commission denied prospective medical expenses noting Petitioner "did not identify prospective medical care as an issue at the time of trial or on its request for Hearing Form." The Commission then remanded the case to the Arbitrator pursuant to §19(b).

On May 15, 2012, the Circuit Court of Cook County issued an order specifying that in the previous remand, the Court did not instruct the Commission to enter an award for the Petitioner, but that its analysis after the remand and award were correct. The Court then again remanded the case to the Commission because the issue of prospective medical treatment was properly before the Commission and it "should have reached a decision on prospective medical." Respondent appealed the decision of the Circuit Court, but on September 14, 2012 the Appellate Court dismissed the appeal for lack of jurisdiction, presumably based on the premise that it was an improper interlocutory appeal. Thereafter, on remand the Commission awarded prospective treatment recommended by Dr. Fisher and Dr. Rosania.

In the instant remand order, the Appellate Court held that on the initial remand, the Commission found Petitioner proved accident/causation but did so based on its interpretation that it was mandated to do so by the Order of the Circuit Court. The Appellate Court found that interpretation was flawed and that the Court order did not include any such mandate. The Appellate Court vacated the initial Commission Decision on Remand and all Commission actions thereafter. Therefore, on the instant remand we appear to be back to square one and we have to analyze the original Decision of the Arbitrator and transcript.

Findings of Fact & Conclusions of Law

1. Petitioner testified that on September 5, 2008, a Friday, he was employed by Respondent, installing heating and refrigeration units. He was assigned to "roofing" at Respondent's building. He "was sent out to pick up roofing equipment." The roof was three to four stories high. He had to lift a 75-pound roll of tar from the ground to the roof pulling it up with a rope. He felt a "little strain" in his back, but continued working, because there was nobody else to do the job. Petitioner went home and "was stuck in bed" over the weekend because his back hurt and was stiff. He "never" had any prior back injuries.

2. The following Monday, he went to work and reported to a boss that he was in pain and needed medical attention. He was sent to Wrigleyville Chiropractic Clinic. He had four treatments there and was referred to Dr. Doblin, who eventually ordered an MRI. After the MRI, Dr. Doblin referred him to Dr. Newman for possible injections. Dr. Newman prescribed physical therapy and referred him to Dr. Arayan for pain management. Dr. Arayan agreed with "Dr. Newman's recommendation to keep" Petitioner off work. Dr. Arayan left the practice and Petitioner began treating with his partner, Dr. Rosania.

3. After two injections and while continuing physical therapy, Petitioner returned to Dr. Newman, who referred him to Dr. Fisher, a spine specialist. They discussed surgery, but Dr. Fisher did not recommend it be done at that time. However, on March 27, 2009, he did recommend surgery, after physical therapy did not help his pain "at all."

4. Petitioner testified that currently, his pain is "at a constant eight." He has a machine that stimulates his back, which he was wearing at the hearing. He never had back pain prior to the instant accident. He was not happy sitting at home in pain all day. He would rather be working and making money.

5. On cross examination, Petitioner testified on the day of the accident he kept working and did not go to an emergency department. He continued working through September 12. He then went to Dr. Singh for a Section 12 medical examination. Petitioner reiterated that he never had any back injury prior to the instant accident. He did not think he ever filed a Workers' Compensation claim previously.

6. On redirect examination, Petitioner testified he would have the recommended surgery if it were awarded.

7. The medical records reveal that on September 8, 2008, Petitioner presented to chiropractor, Dr. Butt, complaining of 6/10 low back pain and 3/10 pain radiating into the left leg. He had these symptoms since a lifting injury on September 5. On examination, Dr. Butt found mild-to-moderate lumbar pain, edema, and hypotonicity. Reflexes were normal, and strength was 5/10 except for the L5 and S1 distribution where it was 4/5. Straight leg raise was positive on the left and negative on the right. Yeoman's test was positive bilaterally, and Bechterew's sitting test, Nachlas test, and Ely's signs were negative bilaterally. Dr. Butt diagnosed lumbago, myalgia/myosotis, sciatica, and pain in thoracic spine. She administered treatment and ordered an x-ray.

8. On September 12, 2008, Petitioner reported some increase of pain, but thought that might be due to increased activity. She performed manipulation and noted increased pain from spasm. She referred Petitioner to Dr. Doblin, a family physician, for consultation on his condition.

9. A lumbar MRI taken on October 2, 2008, showed mild disc degeneration at L4-5 and L5-S1, minimal disc bulge at L5-S1, and mild bulge with small central protrusion at L4-5 with mild narrowing of the spinal canal.

10. Petitioner presented to Dr. Newman on October 21, 2008, reporting an accident on September 12, 2008, in which he was pulling up a roll of taring paper onto a roof and felt pain in his back. He also had to lift an airplane engine that day. He became much worse after four chiropractic sessions. He went to an emergency department and was referred to Dr. Doblin. He obtained an MRI, but Petitioner did not bring it or any medical records to the appointment. He also prescribed injections, which were denied. Petitioner's history was negative for any prior injuries to the low back or left leg. Dr. Newman noted markedly reduced lumbar range of motion. He diagnosed herniated disc with left-sided sciatica primarily at L5-S1. He opined that Petitioner's condition was caused by the reported accident. He referred Petitioner to the pain center for evaluation and possible injections.

11. On October 23, 2008, Petitioner presented to Dr. Arayan on referral from Dr. Newman. He reported injuring his low back on September 12, while roofing when he had to lift heavy objects. He currently had constant 8/10 pain. Dr. Arayan prescribed Vicodin and Lidoderm patch, evaluation for an epidural steroid injection, physical therapy after improvement of pain after the injection, and consideration of an EMG if necessary to delineate the pain generator.

12. On October 31, 2008 and November 14, 2008 Petitioner had epidural steroid injections at L5 and S1.

13. Petitioner returned to Dr. Arayan a week later indicating he had 10% overall improvement after the injections. He reported the first one helped his back pain and the second one helped his leg pain. He wore a brace, which seemed to help somewhat. Dr. Arayan increased the dosage of Percocet, prescribed an EMG, and would consider physical therapy after pain was reduced. The EMG was abnormal and showed radiculopathy at L4-5 and L5-S1. Dr. Arayan noted that he had two injections at L5-S1 with minimal improvement. He recommended a trial of injections at L4-5.

14. On December 18, 2008, Petitioner reported 7/10 pain but 5/10 with Percocet. However, the Percocet made him sleepy. Dr. Arayan noted he had minimal improvement after two injections at L5-S1. He substituted Neurontin for Percocet and prescribed a left-sided injection at L4-5. Dr. Rivera performed left transforaminal epidural steroid injection on January 22, 2009 at L4 and L5 for lumbar radiculopathy.

15. On February 11, 2009, Petitioner presented to Dr. Fisher for a surgical evaluation of lower back/left leg pain, on referral from Dr. Rosania and Dr. Newman. He reported an accident on September 12, 2008 lifting the roll of taring paper which was aggravated by moving an airplane engine later that day. He had physical therapy, chiropractic treatment, medication, and two epidural steroid injections. An EMG showed evidence of radiculopathy on the left at L4-5 and L5-S1. The MRI was overexposed and could not be used for a definitive diagnosis. However, he noted a bulging disc at L4-5, disc space narrowing/disc desiccation/anterior disc herniation at L4-5 mild-to-moderate foraminal stenosis at L4-5, and moderate foraminal stenosis at L5-S1.

16. Dr. Newman noted that Petitioner had failed conservative treatment and wanted to pursue surgery. Dr. Newman would obtain the CD of the MRI to see if he could get a better image.

17. Petitioner returned to Dr. Fisher on March 27, 2009 and reported no change in symptoms. Dr. Fisher's clinical examination was unchanged. He re-reviewed the MRI and diagnosed broad-based disc bulge at L4-5 with bilateral foraminal stenosis, degenerative disc disease at L5-S1 with bilateral stenosis, and radiculopathy at L4-5 and L5-S1 per EMG. Petitioner wanted to pursue surgery. Dr. Fisher recommended laminectomy/foraminotomy at L4-5 and L5-S1.

18. On December 22, 2008, Petitioner presented to Dr. Singh for a Section 12 medical examination at the request of Respondent. At that time, he had undergone two epidural steroid injections and a third had been recommended. Dr. Singh noted the MRI showed disc degeneration at L4-5 and L5-S1 and an EMG showed radiculopathy at those levels. Petitioner complained of 7/10 back pain and left thigh pain. Dr. Singh noted that the MRI showed only a slight loss of signal intensity at L5-S1, slight loss of disc height, and minimal evidence of central or foraminal stenosis. He thought the EMG represented a false positive.

19. Dr. Singh also noted Petitioner's subjective complaints did not correlate to objective findings, he exhibited symptom exaggeration, and positive Waddell signs showing non-organic pain behavior. Dr. Singh opined that Petitioner's current condition was not caused by his accident, he was at maximum medical improvement, no additional treatment was warranted, and he could return to work at full duty.

The Appellate Court vacated all Commission actions after the matter was remanded initially by the Circuit Court. By vacating the Commission actions, the Appellate Court basically nullified those actions and they became legally void and without legal effect. Therefore, the Commission is not legally bound by any of its prior decisions. According to our interpretation of the Decision of the Appellate Court, we are bound only by the initial remand order of the Circuit Court. At that time, the Circuit Court reversed the Commission based on our affirmation/adoption of the Decision of the Arbitrator because it was based on legally improper impeachment based on only the introduction of the prior workers' compensation claim Petitioner filed.

In the remand order, the Circuit Court based its decision on its determination that impeachment by simply introducing the Commission records of a prior claim alleging a prior back injury, without other supporting evidence or questioning the Petitioner about the prior claim, was improper. The Court remanded the case for the Commission to decide the case based on the conflicting medical evidence. In assessing the conflicting medical evidence, on one side there is what appears to be relatively benign MRI findings and the findings of Dr. Singh of symptom magnification positive Waddell signs. On the other side, there is the subjective complaints of Petitioner and the diagnosis of Petitioner's treating doctors that Petitioner had a disc "herniation" which caused mild-to-moderate foraminal stenosis.

18IWCC0131

In this matter, the Commission finds the opinions of Dr. Singh more persuasive than those of Petitioner's treating doctors. The Commission notes that the MRI findings were objectively relatively benign. Petitioner's treating doctors seemed to rely on Petitioner's subjective complaints and the positive EMG. However, the Commission notes that positive EMG findings can be incorrect, and Dr. Singh opined that the EMG results represented a false positive based on the MRI results and his findings of symptom magnification and positive Waddell signs. In addition, Petitioner alleged an accident date of September 5, 2008, but he continued to work in a heavy, physically demanding job in construction for a week, until September 12. Later, he began to allege an accident date of September 12 to various doctors, perhaps to coincide with the last day he worked.

In assessing the entire record before us, the Commission finds that Petitioner did not sustain his burden of proving he suffered a current condition of ill-being of his lumbar spine resulting from an accident on September 5, 2008. Therefore, the Commission affirms the Arbitrator's denial of compensation in this claim.

IT IS THEREFORE ORDERED BY THE COMMISSION the Arbitrator's denial of compensation in this matter is hereby affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner has failed to sustain his burden of proving he sustained a current condition of ill-being of his lumbar spine resulting from an accident on September 5, 2008.

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

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

DATED: MAR 6 - 2018

Deborah L. Simpson

Deborah L. Simpson

Stephen J. Mathis

DLS/dw
O-1/25/18
46

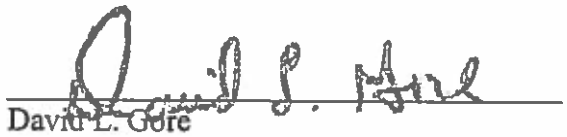
Dissent

I respectfully dissent from the majority decision and would reverse the Arbitrator's decision and find accident and causal connection to Petitioner's condition of ill being.

18IWCC0131

This matter was remanded by the Circuit Court with instructions to decide the case based upon the conflicting medical evidence. As stated by the majority, the conflicting medical evidence consists, on one side, of a "relatively benign" MRI and Dr. Singh's, Respondent's examiner, findings of symptom magnification. On the other side, there are Petitioner's consistent subjective pain complaints, the treators' diagnosis of disc herniation at L4-5 causing a mild to moderate foraminal stenosis and a positive EMG evidencing radiculopathy at L4-5 and L5-S1.

The majority finds the opinions of Dr. Singh to be more persuasive than those of Petitioner's treating doctors. In opining no causal connection to Petitioner's condition of ill being, Dr. Singh reported that he observed symptom magnification and positive Waddell signs and stated that the EMG represented a false positive. However, Dr. Singh provided no bases or explanation for those opinions. The majority fails to acknowledge that a "relatively benign" MRI is not a negative finding. The MRI in question had objective findings at L4-5. Those objective findings were corroborated by the EMG findings of radiculopathy at L4-5, L5-S1. The MRI and EMG findings further support Petitioner's consistent pain complaints. The majority's reliance on Dr. Singh over Petitioner's treating physicians is misplaced. Accordingly, I would reverse the Arbitrator's decision and find that the Petitioner's current condition of ill being is causally related to his accident of September 5, 2008.



David L. Gore

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

18IWCC0131

TRIPLETT, DEMETRIUS
Employee/Petitioner

Case# **08WC047109**

RA SHAVITZ INC
Employer/Respondent

On 09/17/2009, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.21% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
SCOTT GOLDSTEIN
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60610

2542 BRYCE DOWNEY & LENKOV LLC
MICHAEL SCULLY
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

18IWCC0131

STATE OF ILLINOIS)
)
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
19(b) ARBITRATION DECISION

Demetrius Triplett
Employee/Petitioner

Case #08WC047109

v.

RA Shavitz, 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 **Richard A. Peterson**, arbitrator of the Commission, in the city of **Chicago**, on **May 22, and June 22, 2009**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

K. ☒ What amount of compensation is due for temporary total disability?

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

M. ☐ Is the respondent due any credit?

N. ☒ Other Prospective Medical

FINDINGS

- On **September 5, 2008**, the respondent, **RA Shavitz, Inc.**, *was* operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship *did* exist between the petitioner and respondent.
- On this date, the petitioner *did not* sustain injuries that arose out of and in the course of employment.
- Timely notice of this accident *was* given to the respondent.
- In the year preceding the injury, the petitioner earned $**8,181.28**; the average weekly wage was $**438.00**.
- At the time of injury, the petitioner was **32** years of age, ***single*** with **-1-** children under 18.
- Necessary medical services ***have*** been provided by the respondent.
- To date, $**3,920.00** has been paid by the respondent for TTD and/or maintenance benefits.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $**n/a**/week for **-0-** weeks, from **n/a**, through **n/a**, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.
- The respondent shall pay $**-0-** for medical services, as provided in Section 8(a) of the Act.
- The respondent shall pay $**-0-** in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $**-0-** in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $**-0-** in attorneys' fees, as provided in Section 16 of the Act.
- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

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

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

Signature of arbitrator

September 16, 2009
Date

ICArbDec19(b) p. 2

SEP 17 2009

FINDINGS OF FACT

Petitioner testified that he was employed with RA Shavitz, Inc. on Friday, September 5, 2008 and while unrolling tarp and injured his back. He testified he had lower back pain, but did not see a doctor or go to the Emergency Room on September 6, 2008 and September 7, 2008. Petitioner testified that he went to work the following Monday and complained of pain to his supervisor. His supervisor then sent him to the doctor for treatment. Petitioner continued to treat with Dr. Doblin and was then referred to Dr. Fisher at Illinois Bone & Joint for further treatment. (PX 5) Petitioner continued working for the insured through September 12, 2008. Petitioner also had an MRI of the lumbar spine on October 2, 2008, which showed disc bulging at L5-S1 and disc degeneration with a small central protrusion at L4-5. (PX 5) The MRI did not reveal any disc herniation. (PX 5) Petitioner then saw Dr. Newman at Illinois Bone & Joint on October 21, 2008. Dr. Newman took a detailed history from Petitioner and Dr. Newman reported that Petitioner had no prior back injuries. (PX 5)

Further, Petitioner saw Dr. Arayan at the Health Benefits & Pain Management on October 23, 2008. (PX 8) At that time, Petitioner also gave a history of no prior back injuries. (PX 8)

Petitioner saw Dr. Singh for an independent medical examination on December 22, 2008. (RX 1) Petitioner testified that he was truthful and honest in answering Dr. Singh's questions. Dr. Singh diagnosed Petitioner with degenerative disc disease at L5-S1 and a lumbar muscular strain. (RX 1) Dr. Singh noted that Petitioner was at maximum medical improvement at the time of the exam and there was a severe discrepancy between Petitioner's subjective and objective complaints. (RX 1) Dr. Singh noted that he exhibited several Waddell findings upon examination. (RX 1) Dr. Singh reviewed the EMG and was of the opinion that the study showed a false positive, which did not correlate with any of Petitioner's symptoms. Petitioner had hyperexaggeration of his symptoms that did not correlate to any of his objective findings. (RX 1) Petitioner was capable of full duty work without any restrictions at the time of Dr. Singh's exam on December 22, 2008. (RX1)

Petitioner testified both on direct and cross examination that he had no prior low back injuries. Petitioner further testified on direct and cross examination that he never experienced back pain prior to September 5, 2008. Additionally, Petitioner testified that he never filed a workers' compensation claim prior to his current claim in dispute. Petitioner filed a workers' compensation claim on August 28, 2002, alleging an accident date of July 18, 2002 to the lower back. (case number 02 WC 44681) (RX 2) This claim was dismissed in 2006. (RX 2) Further, Petitioner's current Application for Adjustment of Claim reports that Petitioner's Social Security number is 319-74-7720 and has a date of birth of March 27, 1976. (RX 3) Petitioner's prior 2002 filing reports a social security number of 319-74-7720 and a date of birth of March 27, 1976. (RX 2) Further, on Petitioner's current Application the prior 2002 filing is not listed.

Dr. Fisher has recommended an L4-L5 and L5-S1 laminotomy and foraminontomy. (PX 5)

CONCLUSIONS OF LAW

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO F, IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR CONCLUDES AS FOLLOWS:

Respondent's section 12 examiner, Dr. Singh, opined that Petitioner has degenerative disc disease at L5-S1 and suffered a lumbar muscular strain. (RX 1) Dr. Singh also noted that Petitioner had several discrepancies between his subjective and objective complaints. (RX 1) Petitioner experienced positive Waddell findings and had minimal evidence of central foraminal stenosis as shown by his MRI on October 2, 2008. (RX 1) Further, Dr. Singh is of the opinion that the EMG was a false positive and did not correlate with any of Petitioner's symptoms. (RX 1) Dr. Singh noted that Petitioner had exaggerated symptoms, which again did not correlate with any diagnostic or objective findings. (RX 1) Dr. Singh stated Petitioner was capable of full duty work without any restrictions at the time of the exam and was at maximum medical improvement. (RX 1) Dr. Singh did not recommend any further treatment with regard to his injury. (RX 1)

Petitioner is not credible as evidenced by his testimony. Petitioner testified that he had no prior back injuries. But, instead, Petitioner filed a workers' compensation case, 02 WC 44681 on August 28, 2002, alleging an accident date of July 18, 2002, with Phoenix Charter Transport, Inc. (RX 2) In that case, Petitioner alleged injury to the lower back while working. (RX 2) Petitioner's testimony at trial, that he had no prior back injuries, is directly contradicted by that case filing. Petitioner's counsel directly asked if he ever had a prior back injury and Petitioner testified that he did not. The prior workers' compensation claim involved the lower back, which is the same body part in question at present. Further, Petitioner testified at trial that he never experienced back pain prior to the incident on September 5, 2008. This again is in contrast to his prior August 2002, filing where it is evident that he had lower back pain as he claimed a lower back injury. Petitioner also testified at trial that he never filed a workers' compensation case in the State of Illinois. Obviously, that is not the case, since Petitioner did file an Illinois Workers' Compensation claim in August 2002. (RX 2)

Additionally, Petitioner gave histories to his treating physicians that he did not have any prior back injuries. (PX 5, PX 8) Petitioner saw Dr. Newman on October 21, 2008, and Dr. Newman noted that Petitioner's history was negative for any prior back injuries. (PX 5) Petitioner also saw Dr. Arayan on October 23, 2008, and Dr. Arayan noted that Petitioner's history was negative for any prior back injuries. (PX 8) Surely, if Petitioner gave Dr. Newman and Dr. Arayan a history of a prior accident involving the lower back they would have taken that into consideration and documented that. Since Petitioner was not truthful with his treaters, their opinions are of no evidentiary weight since they are based on erroneous information.

The Arbitrator finds the opinions of Dr. Singh to be more credible since he was not operating on incorrect information. Further, the Arbitrator finds that Petitioner is not credible based on his untruthful testimony at trial. Petitioner has not been truthful as seen from the evidence presented by Respondent. Petitioner did have a prior back injury, did have prior back pain, and did file a prior workers' compensation claim before his September 5, 2008, incident. Just as Dr. Singh found Petitioner to exaggerate his symptoms, Petitioner has not been truthful with his past history. Therefore, the Arbitrator concludes that Petitioner's present condition of ill-being is not causally connected to his accident of September 5, 2008.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO ALL OTHER ISSUES IN THIS CASE, THE ARBITRATOR CONCLUDES AS FOLLOWS:

The Arbitrator has concluded above that Petitioner's present condition of ill-being is not causally connected to his accident of September 5, 2008. Therefore, all other issues in this case are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Leonard,

Petitioner,

vs. NO: 12WC 30189

Keating National Exterior/Illinois State Treasurer as ex-officio of the Injurd Workers' Benefit Fund,

Respondent.

18IWCC0132

DECISION AND OPINION ON REVIEW

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

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

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

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

18IWCC0132

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

Bond for removal of this cause to the Circuit Court by Respondent 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: MAR 8 - 2018
o022818
LEC/jrc
043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LEONARD, DAVID
Employee/Petitioner

Case# **12WC030189**

KEATING NATIONAL EXTERIOR/ILLINOIS STATE TREASURER AS EX-OFFICIO OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

18IWCC0132

On 3/29/2017, 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 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:

2489 BLACK AND JONES LAW FIRM
JASON EDMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0000 KEATING NATIONAL EXTERIOR
922 W LOCUST ST
BELVIDERE, IL 61008

5946 ASSISTANT ATTORNEY GENERAL
HELEN LOZANO
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

David Leonard
Employee/Petitioner

v.

Keating National Exterior / Illinois State Treasurer as ex-officio of the Injured Workers' Benefit Fund
Employer/Respondent

Case # 12 WC 30189

Consolidated cases:

18IWCC0132

An *Application for Adjustment 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 **Rockford, Illinois**, on **February 17, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

18IWCC0132

On the date of accident, **December 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 these accidents *was* given to Respondent.

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

In the year preceding the injury, Petitioner's average weekly wage was **$480.00**.

On the date of accident, Petitioner was **36** years of age, ***single*** with **1** dependent child.

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

ORDER

Respondent shall pay the Petitioner temporary total disability benefits of $ **320.00** /week for **14-6/7** weeks, from **December 2, 2011 through March 15, 2012**, as provided in Section 8(b) of the Act.

Respondent shall pay $ **$95,701.88** for necessary medical services, as provided in Section 8(a) and 8.2 of the Act and consistent with the medical fee schedule.

Respondent shall pay Petitioner the sum of **$288.00** / week for a period of **100** weeks, as provided in Section 8(d)(2) of the Act, because the injuries sustained caused **20%** **loss of a man as a whole.**

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

3/28/17
Date

ICArbDec

MAR 29 2017

STATEMENT OF FACTS

Petitioner testified that on December 1, 2011 he was employed by Keating National Exterior, owned by Sean Keating. He obtained this job after meeting with and being hired by Sean Keating approximately 3 months prior. Petitioner testified that he performed roofing work on both new construction and existing homes. Petitioner worked approximately 40 hours a week, being paid $12 - $15 per hour depending on the height and pitch of the roof he was working on. His schedule was set by Sean Keating and he was told what he would be paid prior to performing the work. Petitioner was paid in cash and no taxes were taken out of his pay. He was paid by Mr. Keating on a weekly basis. Petitioner testified that he did not wear a uniform, but Mr. Keating provided his employees with Keating National Exterior sweatshirts to wear. Petitioner was also provided business cards for Keating National Exterior to hand out. A copy of the business card was offered into evidence as Petitioner's Exhibit 3.

Petitioner testified that he performed roofing work, tearing down old roofs and building new ones, laying tar paper and shingles. He used tools such as hammers and tape measures, and power tools such as grinders and metal cutters. Petitioner brought some of his own hand tools, but the power tools and all materials were provided by Respondent. Petitioner testified that Respondent had approximately 15-20 employees that he was aware of. Petitioner testified that he would be able to decline a job, but that he never did as he would have been fired if he had declined any work. He was not allowed to have other employment while working for Keating National Exterior as he was expected to work for Respondent on a full time basis. Petitioner testified that if it rained hard enough, they would not work, but he worked 40 hours a week approximately 90% of the time. Petitioner testified that his work was inspected by Sean Keating or Brian Blodget, the foreman. If work was not satisfactory, it would impact the assignments provided to the employees.

Petitioner testified that he arrived at the job site on December 1, 2011. Upon arrival, he was met by the Foreman who told him and the other employees what to do that day. He was to work on a Spanish tile roof. The valley seams needed to be filled with foam. Petitioner indicated that he informed the foreman and Sean Keating that there was frost on the roof. Petitioner stated that Sean Keating informed him to do the work or find a new job. As such, Petitioner began working. While on the roof, Petitioner slipped on frost and slid off the roof, falling to the ground. Petitioner estimated he fell approximately 10-12 feet, landing on his legs. After falling, he could not stand. He called out for help and another worker brought him a phone. Petitioner called Sean to tell him what happened. The foreman then took Petitioner to St. Anthony Medical Center.

Petitioner was admitted to St. Anthony Medical Center immediately after the December 1, 2011 injury. He was diagnosed with a closed fracture of upper end of right tibia and closed fracture of the L2 vertebra. Petitioner was discharged on December 4, 2011. Surgery was recommended for the tibia fracture once swelling decreased. He was to follow with Dr. Sorkin with Rockford Orthopedic Associates. (Px. 6)

Petitioner was seen by Dr. Sorkin on December 9, 2011 and underwent open reduction and internal fixation of the highly comminuted right unicondylar tibial plateau fracture with bone graft of the proximal tibia. (Px. 8) Petitioner was subsequently placed in a knee brace. He underwent physical therapy at Belvidere Rehab & Sports Medicine. (Px. 9) Petitioner testified that he was taken off work and he provided an off work note to Sean Keating.

Petitioner saw Dr. Alexander regarding his lumbar vertebral body fracture. While hospitalized, Dr. Alexander saw Petitioner in consultation. At that time, the doctor recommended conservative management. Petitioner saw Dr. Alexander on two occasions post hospitalization, December 29, 2011 and January 30, 2012. At the last visit on January 30, 2012, Petitioner reported that he was doing well. He denied any back pain or radicular pain. X-rays of the lumbar spine showed a healing fracture. There was good alignment. Dr. Alexander felt Petitioner was doing well and should require no further treatment. Petitioner was released at that time. (Px. 7)

Petitioner continued in physical therapy at Belvidere Rehab & Sports Medicine. Therapy records show that on March 16, 2012, Petitioner reported stiffness and soreness which he attributed to returning to work the previous day, or March 15, 2012. Petitioner reported that he worked approximately 7-8 hours of substantial walking on uneven ground. (Px. 9)

According to the records submitted, Petitioner last therapy session was on March 30, 2012. At that time it was noted Petitioner indicated that he was working and that overall, his right knee seemed to tolerate the work relatively well. Petitioner did report concerns that when ambulating on uneven ground he experienced discomfort in the knee. He reported that at the end of the day, the knee was quite swollen, stiff and sore. Petitioner was recommended to continue physical therapy one to two times per week. (PX. 9)

Petitioner continued to treat with Dr. Sorkin. On September 5, 2012, Dr. Sorkin performed an x-ray that revealed sequela of ORIF about the right knee. He noted that Petitioner could undergo surgery to include removal of the hardware. (Px. 8) Petitioner testified that he decided not to undergo the additional procedure.

Petitioner testified that he returned to work for Respondent approximately one year after his injury, doing light work. He would run for supplies and do light activity, but only did so for about a month until Respondent ran out of things for him to do within his limitations. Since then, Petitioner has returned to limited construction work. He has done some siding and remodeling work.

Petitioner testified that his injury limits the extent that he can perform his prior employment. Petitioner indicated that he can no longer climb ladders. He wears a knee brace, but cannot kneel or crawl. He describes numbness from his right knee down to his shin. He has ongoing back pain. The Arbitrator notes that Petitioner appeared at the hearing with a noticeable limp. Petitioner provided that he cannot walk down stairs without turning sideways to do so. He has to limit the amount he stands in a day. While he once worked 12-14 hour days, he now has difficulty getting through an 8-hour work day. He can no longer run.

Notice of the trial date was attempted on Respondent. (Px. 5) Petitioner offered a certificate of noncompliance from the NCCI confirming that Respondent failed to have insurance. (Px. 4) Finally, Petitioner offered exhibits 1 and 2 which were the original Application for Adjustment of Claims and the Amended Application for Adjustment of Claims, adding the Injured Workers Benefit Fund as a party to the case. (Px. 1, 2)

With respect to A.) Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act, the Arbitrator finds as follows:

The Arbitrator finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act on December 1, 2011. Petitioner testified that he was hired by Sean Keating do roofing work for Keating National Exterior. This conversation and job offer took place in the State of Illinois.

Keating National Exterior maintained a place of business located in Belvidere, Illinois. Also, the injury itself took place in Illinois. Therefore, jurisdiction is proper here in Illinois.

Petitioner testified that his job was as a construction laborer for Keating National Exterior involving the remodeling, altering or demolishing of structures, the use of sharp edged cutting tools such as hammers, knives, and more. The work also involved use of electric or gasoline powered driven equipment, such as grinders and metal cutters. Therefore, the work is subject to the Illinois Worker's Compensation Act consistent with 820 ILCS 305/3(1, 2, 8, 15).

The provisions of the Act apply automatically to any business or enterprise in which electric, gasoline, or other power driven equipment is used in the operation thereof, businesses engaging in the erection, maintaining, removing, remodeling, altering, or demolishing of structures, construction, or any enterprise in which sharp edged cutting tools are used. The Arbitrator finds Petitioner's testimony credible and finds automatic coverage under Section 3 of the Illinois Workers Compensation Act on December 1, 2011.

With respect to B.) Was there an employee-employer relationship, the Arbitrator finds as follows:

The Arbitrator finds that there was an employee-employer relationship between Petitioner and Keating National Exterior. Petitioner testified that he was hired by Sean Keating to perform construction labor for Keating National Exterior. Petitioner testified that Sean Keating set his schedule and the hourly rate to be paid for the various jobs he performed. Petitioner's work was dictated and controlled by Respondent. Sean Keating or Brian Blodget, the foreman, inspected Petitioner's work. Petitioner was not able to take other employment or turn down work with Keating National Exterior. He was paid weekly based on the hours he worked. Respondent provided Keating National Exterior sweatshirts to the employees to wear and gave them business cards to hand out. All of this information was uncontradicted at trial. Further, the Arbitrator finds Petitioner credibly testified to his employment relationship with Respondent. Therefore, the Arbitrator finds that there was an employee-employer relationship between Petitioner and Keating National Exterior on December 1, 2011.

With respect to C.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner sustained an accidental injury that arose out of and in the course of his employment with Respondent on December 1, 2011. Petitioner testified that on that day, while working on a roof, he slipped on frost and fell 10-12 feet to the ground. Petitioner's emergency room record indicated that while at work, he fell from a roof about 15 feet high, sustaining a lumbar spine fracture and right tibial plateau fracture. He was immediately provided treatment for those injuries. Petitioner's testimony regarding the accident was uncontradicted at trial and is clearly supported by the treatment records. As such, the Arbitrator finds that Petitioner suffered an injury that arose out of and in the course of his employment with Keating National Exterior on December 1, 2011.

With respect to D.) What was the date of the accident, the Arbitrator finds as follows:

The Arbitrator finds that the date of the accident was December 1, 2011. Petitioner was seen in the Emergency Room at St. Anthony Hospital shortly after his injury. The medical records support an injury date of December 1, 2011. As it conforms to proofs, the Arbitrator finds that Petitioner's accident occurred on December 1, 2011.

With respect to E.) Was timely notice of the accident given to Respondent, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner provided timely notice of the accident to Respondent, Keating National Exterior. Petitioner testified that he was working with the owner of Keating National Exterior, Sean Keating, at the time of his injury. Petitioner testified that he called Mr. Keating while on the ground after falling from the roof. Brian Blodget, the foreman for Keating National Exterior, took Petitioner to the emergency room immediately after the injury occurred. No evidence was provided to contradict Petitioner's testimony. Therefore, the Arbitrator finds that timely notice was given by Petitioner to Respondent.

With respect to F.) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner's present condition of ill-being is causally related to the injury that occurred on December 1, 2011. On the date of injury, Petitioner was immediately transported to the emergency room where he was diagnosed with an L2 compression fracture and a right tibial plateau fracture. Based on the medical records, there is a clear chain of events which connect the compression fracture and the tibial plateau fractures to the accident. Petitioner testified that he had broken his femur in 2005 after a car accident, but had recovered fully and was receiving no treatment for his right leg or lower back subsequent to his injury. Based on the records from St. Anthony Hospital, Dr. Sorkin, and Dr. Alexander, the surgery Petitioner underwent to his right leg, and the physical therapy he underwent after the injury were related to the accident. Petitioner continues to experience difficulty walking, kneeling, and crawling due to the condition of his leg. Dr. Sorkin noted the possibility of additional surgery to Petitioner's right knee as of September 5, 2012. Petitioner also continues to have pain in his lower back. His ongoing symptoms are consistent with the injuries suffered and no contradictory medical evidence was admitted at trial. Therefore, the Arbitrator finds that Petitioner's present condition of ill-being is causally related to his December 1, 2011 injury.

With respect to G.) What were Petitioner's earnings, the Arbitrator finds as follows:

Petitioner alleges an average weekly wage of $480.00. Petitioner testified that depending on the job he was performing, he was paid between $12 to $15 per hour. Petitioner testified that he worked 40 hours a week approximately 90% of the time, only working less when it rained heavily. That testimony went unrebutted. Petitioner was unable to offer pay stubs or copies of checks because he was paid in cash by Respondent. The Arbitrator finds that at 40 hours a week at a rate of $12 per hour, Petitioner earned $480.00 per week.

With respect to H.) What was Petitioner's age at the time of the accident, the Arbitrator finds as follows:

Petitioner testified that he was born on October 14, 1975 and was 36 years old at the time of his injury. Respondent offered no evidence to refute Petitioner's testimony. His medical records confirm his date of birth. Therefore, the Arbitrator finds that Petitioner was 36 years old at the time of his injury on December 1, 2011.

With respect to I.) What was Petitioner's marital status at the time of the accident, the Arbitrator finds as follows:

Petitioner testified that he was single, with 1 dependent child under the age of 18 at the time of his December 1, 2011 injury. Respondent offered no evidence to refute Petitioner's testimony. Therefore, the

Arbitrator finds that Petitioner was single and with 1 dependent child at the time of his December 1, 2011 injury.

With respect to J.) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary for the injuries he sustained on December 1, 2011. The Arbitrator notes that the medical records, diagnoses, treatment carried out, and treatment recommendations are noted in the Statement of Facts. The Arbitrator finds that the Respondent failed to offer any evidence to refute the reasonableness and necessity of the medical treatment received by Petitioner for his injuries. Therefore, the Arbitrator finds that the treatment Petitioner received at OSF Medical Center, Rockford Orthopedics (Ortho IL), Rockford Radiology, Belvidere Rehab, and Dr. Alexander were reasonable and necessary for his injury.

Based on the Arbitrator's findings that Petitioner suffered an injury that arose out of and in the course and scope of his employment for Respondent, Keating National Exterior, and that the treatment Petitioner received was reasonable and necessary, the Arbitrator finds that Respondent is liable for the treatment provided, as set forth in Petitioner's Exhibit 10. As such, Respondent is liable for the unpaid medical bills, pursuant to the medical fee schedule, totaling $95,596.88. Further, Petitioner is to be reimbursed for the $105.00 out of pocket expenses paid to Dr. Alexander.

With respect to K.) What temporary benefits (TTD) are in dispute, the Arbitrator finds as follows:

Petitioner was off work following his injuries, and underwent surgery and physical therapy to treat his tibial plateau and lumbar spine fractures. Petitioner's medical records note that he required physical therapy and continued to experience symptoms. Petitioner testified that he continued to be significantly limited and did not return to work for over a year after his December 1, 2011 injury. However, physical therapy records from Belvidere Rehab & Sports Medicine show that on March 16, 2012, Petitioner reported stiffness and soreness which he attributed to returning to work the previous day, or March 15, 2012. Petitioner reported that he worked approximately 7-8 hours that day. It appears Petitioner continued to work as the records from Petitioner's last therapy session of March 30, 2012 show he reported that he was still working and that overall, his right knee seemed to tolerate the work relatively well.

Petitioner testified that when returned to work for Respondent, he would run for supplies and do light activity, but only did so for about a month until Respondent ran out of things for him to do within his limitations. Since then, Petitioner has returned to limited construction work. He has done some siding and remodeling work. The Arbitrator notes that the record is void of any off work slips or any documented light duty restrictions. The Arbitrator finds that Petitioner returned to work on March 15, 2012 and as such was temporarily and totally disabled for work from December 2, 2011 through March 15, 2012, 14-6/7 weeks

With respect to L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

With regard to 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 performed primarily roofing work, which involved tearing down old roofs and building new ones, laying tar paper and shingles. Petitioner testified that since his injury he has returned to work and continued to engage in remodeling and siding. However, he has been unable to accept some construction projects due to his inability to ascend or descend stairs, climb ladders, stand or walk for longer than eight hours, and cannot kneel or crawl. Petitioner is limited to working on ground level. Because of this, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 36 years old at the time of the accident. Because Petitioner is an individual who will live with his permanent disability for a longer period than an older individual, the Arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, as noted above, Petitioner primarily performed roofing work. Although Petitioner has returned to work engaging in remodeling and siding, he has been unable to accept some construction projects due to his inability to ascend or descend stairs, climb ladders, stand or walk for longer than eight hours, and cannot kneel or crawl. Petitioner is limited to working on ground level. As such, the Arbitrator gives greater weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner sustained a closed fracture of upper end of right tibia and closed fracture of the L2 vertebra. He ultimately underwent an open reduction and internal fixation of the highly comminuted right unicondylar tibial plateau fracture with bone graft of the proximal tibia. Post-operatively, he underwent physical therapy through March 30, 2012. At that time, Petitioner expressed that when ambulating on uneven ground he experienced discomfort in the knee. He reported that at the end of the day, the knee was quite swollen, stiff and sore. Petitioner credibly testified to his ongoing issues. He can no longer climb ladder, kneel, or crawl, limiting the construction jobs he can now perform. He has difficulty going down stairs or standing for a full 8-hour day. He walks with a prevalent limp and has ongoing pain in his back and leg. With respect to his low back condition, Petitioner treated conservatively, seeing his treating physician on two occasions. While Petitioner is able to perform some construction work, he has lost the ability to perform many of the activities necessary to perform such jobs. He has not completely lost his career; however, his ability to perform much of what he did in that field is no longer possible.

Based on the above, the Arbitrator finds that as a result of the accident sustained, Petitioner is permanently disabled to the extent of 20% pursuant to Section 8(d)(2) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Virginia Cole,
Petitioner,

vs. NO: 12WC 22559

State of Illinois - DORS,
Respondent.

18IWCC0133

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, timely notice of accident, causal connection, temporary total disability, nature and extent, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

DATED: MAR 8 - 2018
o022818
LEC/jrc
043

L. Elizabeth Coppoletti
L. Elizabeth Coppoletti

Charles J. DeVriendt
Charles J. DeVriendt

Joshua D. Luskin
Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLE, VIRGINIA
Employee/Petitioner

Case# **12WC022559**

STATE OF ILLINOIS DORS
Employer/Respondent

18IWCC0133

On 11/2/2016, 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 0.50% 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:

2489 BLACK AND JONES
TRACY L JONES
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

5782 ASSISTANT ATTORNEY GENERAL
KELLY KAMSTRA
100 W RANDOLPH ST 13TH FL
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0502 STATE EMPLOYEES RETIREMENT
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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

NOV 2 - 2016

GERALD A. HASSIN, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF WINNEBAGO)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Virginia Cole
Employee/Petitioner

Case # **12** WC **22559**

v.

18IWCC0133

State of Illinois DORS
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **September 20, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 1, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,387.88**; the average weekly wage was **$661.31**.

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

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

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

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

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

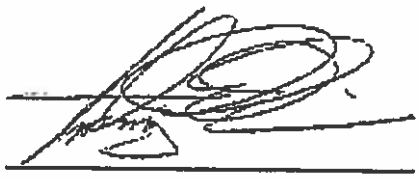
ORDER

The Petitioner failed to prove that an accident occurred which arose out of and in the course of her employment with the Respondent. The Petitioner's claim for benefits is, therefore, denied.

No benefits are awarded herein.

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

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



Arbitrator Anthony C. Erbacci

October 28, 2016
Date

NOV 2 - 2016

FACTS:

The Petitioner testified that on March 1, 2012, while performing the usual duties of her employment with the Respondent as a personal assistant, she fell while climbing off of some milk crates that she had stacked up in order to change a lightbulb. The Petitioner testified that when she fell off of the milk crates, she struck her right knee and experienced immediate pain in that knee. The Petitioner testified that she continued to work the rest of that day and that she also worked the following day. The Petitioner testified that she then sought treatment for her complaints of right knee pain with her primary care physician, Dr. Ashaye at Crusader Community Health.

The Petitioner testified that at some time after the incident occurred, on an unknown date, she went to a Department of Rehabilitation Services office to report her injury. The Petitioner testified that she asked to speak to "Allen," but Allen refused to speak to her and sent a woman out in his place. The Petitioner could not provide Allen's last name and could not provide the name of the woman with whom she spoke. The Petitioner testified that the woman did not allow her to report her injury, telling the Petitioner that she was an employee of the state, not DORS, and that the woman was not authorized to speak to her.

On June 29, 2012 the Petitioner filed an Application for Adjustment of Claim and on July 7, 2012 she filed a Workers' Compensation Employee's Notice of Injury form. At hearing, the Petitioner testified she did not remember filling out this form but she did confirm that she signed it.

The medical records of the Crusader Community Health demonstrate that the Petitioner called there on March 6, 2012 advising that her right knee was very painful and that she could not straighten it when standing. It is noted that the Petitioner reported that she "does not remember hurting or straining her knee." When she saw Dr. Ashaye on March 7, 2012, it was noted that the Petitioner complained of right knee pain and swelling and that she reported having pain in the right knee for four days with no trauma, no motor vehicle accident and no old injury. The Petitioner was noted to have reported that her "jobs involved standing a lot."

At hearing, the Petitioner denied having right knee problems or osteoarthritis prior to March 1, 2012. She acknowledged, however, that the records of Crusader Community Health demonstrate that she did make complaints of right knee pain on February 23, 2012. Nonetheless, the Petitioner testified that she never had any knee pain until she fell on her right knee on March 1, 2012.

The Petitioner's testimony and the medical records reflect that the Petitioner was initially treated with pain medication and, when her complaints of pain continued, an MRI was ordered. The MRI was performed on March 22, 2012 and was reported to demonstrate a complex degenerative tear of the posterior horn of the medial meniscus, bone marrow edema involving the medial tibial plateau consistent with bone contusion, and moderate joint effusion with a Baker's cyst. After the MRI, the Petitioner was referred to an orthopedist, Dr. Anton.

On April 9, 2012, Petitioner presented to Dr. Anton, with a complaint of right knee pain "which has been present for approximately 3 months time without injury." Dr. Anton noted that he had reviewed the Petitioner's MRI and that the Petitioner wished to proceed with a right knee arthroscopy

to "take care of the meniscal tear". Dr. Anton further noted that he "had a long discussion with her [the Petitioner] about her established arthritis in her knee which could be causing a great deal of pain as well, and I have told her that this pain may persist post-operatively. She says she understands and wishes to proceed."

On April 20, 2012, the Petitioner underwent a right knee partial medial meniscectomy and partial lateral meniscectomy. Dr. Anton's records indicate that the Petitioner returned to work three days after the surgery. The Petitioner testified that she continued treating with Dr. Anton, who also prescribed physical therapy and a series of injections. The Petitioner did not complete her prescribed course of physical therapy. The Petitioner testified that the physical therapy was not helping her and the physical therapy records indicate that she was discharged due to not attending her physical therapy appointments. The Petitioner testified that her knee continued to be symptomatic subsequent to the surgery and that she continued to see Dr. Anton for her complaints.

On March 12, 2013, the Petitioner underwent an x-ray evaluation of her right knee for her continued right knee pain. This x-ray revealed no acute fractures or dislocations, but it did reveal mechanical alignment as genu varum deformity (bow leggedness) with near bone on bone arthritis in the medial compartment. The Petitioner testified that she continued to follow up with Dr. Anton approximately every three months and that in September 2014, Dr. Anton discussed the option of a total knee replacement.

At the request of her attorney, the Petitioner was examined by Dr. Jeffrey Coe on November 5, 2013. Dr. Coe also reviewed records from Dr. Ashaye and Dr. Anton and x-ray and MRI reports but not the diagnostic films. Following his examination and review of medical records, Dr. Coe opined that the Petitioner suffered a contusion and strain injury to her right knee on March 1, 2012. Dr. Coe diagnosed Petitioner with an acute right knee medial meniscal tear and aggravation of preexisting asymptomatic degenerative arthritis of the right knee. Dr. Coe concluded his report by opining that "the condition of Ms. Cole's right knee could or might be causally related to the history of right knee injury at her client's home as she described the events of the accident to me." Dr. Coe's deposition testimony of November 5, 2013 was admitted into the record as Respondent's Exhibit 5.

In December 23, 2015, Dr. Anton referred the Petitioner to Dr. Dannenmaier for a total knee replacement, which was performed on February 22, 2016. The Petitioner testified that following her total knee replacement, Dr. Dannenmaier prescribed physical therapy and instructed her to remain off work. The Petitioner testified that Dr. Dannenmaier released her from treatment on May 24, 2016 and that she has received no additional treatment for her right knee since that time.

The Petitioner testified that she returned to work after her release and that she is now working as a housekeeper at an assisted living facility. She testified that works forty hours per week earning $9.50 per hour and can work without restrictions. The Petitioner testified that her current job duties are similar to those she performed in her employment with the Respondent. The Petitioner testified that she currently experiences occasional pain and swelling in her right knee.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

It is axiomatic that the Petitioner bears the burden of proving all of the elements of her claim by a preponderance of the credible evidence. The Arbitrator finds that the Petitioner failed to meet her burden of proof here.

In so finding, the Arbitrator notes that the Petitioner testified to a specific accident which occurred on March 1, 2012 when she fell off of some stacked milk crates and injured her right knee. The Petitioner also testified that she had no right knee pain or problems prior to that injury. The Petitioner's testimony, however, finds no support in any of the treating medical records. In fact, the medical records contradict the Petitioner's testimony in several respects.

The records demonstrate that the Petitioner did voice complaints of right knee pain prior to March of 2012 when, on February 23, 2012, she reported to Crusader Community Health that she had right knee pain. The records of Crusader Community Health further demonstrate that the Petitioner called there on March 6, 2012 advising that her right knee was very painful and that she "does not remember hurting or straining her knee." When she saw Dr. Ashaye on March 7, 2012, the Petitioner complained of right knee pain and swelling and she reported having pain in the right knee for four days with no trauma, no motor vehicle accident and no old injury. When she saw Dr. Anton on April 9, 2012, the Petitioner reported that her right knee pain had been present for approximately 3 months "without injury".

The Arbitrator notes that the first time a specific history of a work accident appears in any record is the Workers' Compensation Employee's Notice of Injury form filed by the Petitioner on July 7, 2012, four months after the alleged injury and two months after she underwent her right knee arthroscopy. The first time a specific history of a work accident appears in any medical record is in the November 5, 2013 report of Dr. Coe, who the Petitioner saw at the request of her attorney almost one year after the alleged injury and seven months after she underwent arthroscopic surgery for her knee complaints.

The Arbitrator finds it very difficult to believe that had the Petitioner injured her knee in the manner she described at hearing, a specific history of that injury would not be recorded anywhere in the records of her initial treating physicians and that those records would all indicate that the Petitioner's knee complaints arose "without injury". The Arbitrator finds that the Petitioner's testimony as to her alleged work accident is unsupported by any credible evidence in the record and, therefore, questions the veracity and reliability of the Petitioner's testimony.

Based upon the forgoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an accident occurred which arose out of and in the course of her employment with the Respondent.

Having found that the Petitioner failed to prove that an accident occurred which arose out of and in the course of her employment with the Respondent, determination of the remaining disputed issues is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FRANCIS BERKOWICZ,

Petitioner,

vs.

NO: 06 WC 21336

CITY OF CHICAGO, BUREAU OF SANITATION,

Respondent.

18IWCC0134

DECISION AND OPINION ON REVIEW

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

Initially, the Commission observes there are two typographical errors in the Arbitrator's decision: the Order portion and the second full paragraph on page 7 indicate a May 8, 2016 accident date. The Commission corrects these to reflect a May 1, 2006 date of accident.

The Arbitrator concluded Petitioner established odd-lot permanent total disability:

> Once Petitioner established that he was unable to return to his usual and customary line of employment on account of his injuries, and once he further established that he had engaged in an unsuccessful good faith effort to find employment, the burden shifted to Respondent to demonstrate the availability of suitable work. This has not been done. Respondent's labor market survey merely lists a number of sedentary to light duty jobs, all of which require skills or experience which Petitioner lacks. While the parking lot attendant position exists, and perhaps it is a viable job for Petitioner, Petitioner was unable to obtain placement in his job. As Kelman said in

his report, these jobs are hard to obtain.
Based on the foregoing, the Arbitrator concludes that Petitioner is permanently and totally disabled pursuant to Section 8(f) of the Act.

Respondent argues this finding is erroneous because Petitioner's job search was not diligent. Respondent further contends Petitioner failed to establish no stable labor market exists and notes its labor market survey reflects available positions in Chicago with an earning potential of $10 to $16 per hour. Respondent additionally argues Petitioner is not entitled to a wage differential because he "did not afford the respondent an opportunity to result (sic) the second prong under 8(d)1, that being the impairment of earnings," and instead posits the proper award is 40% loss of the person as a whole.

The Commission finds Respondent's arguments are not well-founded in the record. Throughout its argument, Respondent repeatedly highlights Petitioner did not request vocational services from it. Rule 7110.10 (in effect at the time of hearing) requires the employer or its representative, in consultation with the claimant, to prepare a written assessment addressing the necessity of a rehabilitation program; this mandate is triggered when "it can be reasonably determined that the injured worker will, as a result of the injury, be unable to resume the regular duties in which engaged at the time of injury, or when the period of total incapacity for work exceeds 120 continuous days." *50 Ill. Adm. Code 7110.10(a).* (Such rule was amended in 2016 and among other changes, lengthened the incapacity period to 365 days. *50 Ill. Adm. Code 9110.10(a)*). Petitioner underwent a left total knee replacement on August 8, 2015 (PX1) and was subsequently released to return to work with a 40 lbs. restriction by Dr. Westin as of November 16, 2015. PX2. Petitioner moved to Arizona in November of 2015. T. 35. Mr. Kelman prepared a vocational assessment at the request of Petitioner on April 27, 2016 following a meeting with Petitioner on January 15, 2016. PX3; T. 58. Thereafter Ms. Stafseth prepared a labor market survey on June 24, 2016. RX5. Based on the evidence in the record, it is unclear whether employer or its representative was afforded an opportunity to consult with claimant and/or its representative in preparation of a written assessment. In any event, as Ms. Stafseth never met with Petitioner, did not know his educational background or complete work history, and was not aware whether he possessed any keyboarding or computer software proficiency, the Commission finds her conclusions as to suitable job targets and associated earnings are not persuasive. *See, e.g., Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC, ¶36 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.) Although Respondent's arguments on the issue are not well-founded, the Commission finds Petitioner's own vocational evidence precludes a finding of odd-lot permanent total disability.

Petitioner met with Mr. Kelman in January of 2016. In his report from that assessment, dated April 27, 2016, Mr. Kelman concluded Petitioner will be very limited with regard to what jobs would be reasonably available to him given his education, work history in one area with no transferable skills, and the work restrictions as set forth by Dr. Westin. Given the totality of information including Petitioner's education, vocational and medical profile, Mr. Kelman indicated Petitioner was "potentially totally disabled." In the very next sentence, however, Mr. Kelman observed "the work restrictions by Dr. Westin may suggest that he can do Parking Lot Cashier positions wherein he would have the opportunity to do a combination of sitting/standing." Mr. Kelman then documented the results of his labor market survey for parking lot cashier jobs

and stated: "The above-referenced employers have had recent openings and they would be considered unskilled positions. These positions do allow for a sit/stand option which would be appropriate for Mr. Berkowicz" PX4. Mr. Kelman concluded, "It is the opinion of this Consultant that the Parking Lot Cashier positions best represent Mr. Berkowicz's earning capacity based on education, work history, and medical profile of restrictions as set forth by Dr. Westin." PX4.

The Arbitrator acknowledged the seeming suitability of this position but found, "While the parking lot attendant position exists, and perhaps it is a viable job for Petitioner, Petitioner was unable to obtain placement in his job." The Commission has analyzed Petitioner's job search logs and finds they do not reflect job search efforts directed toward parking lot attendant positions. Instead, this exhibit demonstrates the only parking lot positions investigated were applications to Ace Parking Management on April 7, 2016 and again to Ace Parking on August 18, 2016. PX8. Moreover, the Commission finds the arbitrator's assertion that Mr. Kelman's report indicates "these jobs are hard to obtain" to be inaccurate; to the contrary, Mr. Kelman's report states, "These positions are reasonably available." PX4. "Suitable employment is employment which the claimant is both able and qualified to perform." *Crittenden v. Illinois Workers' Compensation Commission*, 2017 IL App (1st) 160002WC, ¶24, 73 N.E.3d 654. The Commission finds Petitioner's vocational expert established the availability of suitable employment as a parking lot attendant. Therefore, the Commission finds Petitioner failed to prove odd-lot permanent total disability and vacates the award of permanent total disability benefits.

Where a claimant's attempt to establish permanent total disability is unsuccessful, it is incumbent upon the Commission to alternatively consider the claimant's entitlement to wage differential benefits. See *Lenhart v. Illinois Workers' Compensation Commission*, 2015 IL App (3d) 130743WC, ¶52, 29 N.E.3d 648:

> In cases where a claimant unsuccessfully seeks PTD benefits and does not make an alternative request for PPD benefits, the claimant is still entitled to PPD benefits when the evidence supports such an award. Likewise, in such cases, we believe 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 (regardless of which party presented the evidence), and when nothing in the record suggests that the claimant elected to waive his right to recover such an award.

Under Section 8(d)1, an impaired worker is entitled to a wage differential award when (1) he is "partially incapacitated from pursuing his usual and customary line of employment" and (2) there is a "difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1* (West 2012). The evidence is clear Petitioner's permanent restrictions prohibit him from resuming his career as a union hoisting engineer; therefore, the first element is satisfied. The evidence is similarly uncontroverted Petitioner sustained an impairment in earnings. As the record establishes both elements of a wage differential, the analysis turns to the proper calculation of that benefit.

Calculating the wage differential rate requires the Commission to make two earnings

18IWCC0134

determinations: (1) "the average amount which he would be able to earn in the full performance of his duties in the occupation in which…he was engaged at the time of the accident," and (2) "the average amount which he…is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1*. The parties stipulated Petitioner's average weekly wage in the 52-week period prior to his 2006 accident was $1,428.00. ArbX1. As Petitioner was pursuing odd-lot permanent total disability, he did not present direct evidence of what he would currently be earning in the full performance of his job. The Commission observes, however, the vocational assessment evidences the hourly wage at Respondent had increased to $48.10. Given Petitioner's 40-hour workweek, the Commission finds his earnings in the full performance of his pre-accident job would be $1,924.00 ($48.10 x 40 = $1,924.00).

As to the second earnings determination, the suitable employment Petitioner is "able and qualified to perform" is parking lot attendant. Mr. Kelman calculated the composite average wage for this position at $9.15 per hour. Therefore, the Commission concludes the appropriate measure of Petitioner's earning capacity is $366.00 per week ($9.15 x 40 = $366.00).

The above findings yield a wage differential of $1,558.00 ($1,924.00 - $366.00 = $1,558.00). This amount, however, exceeds the statutory maximum rate for Petitioner's date of accident. See, *Dibenedetto v. Illinois Workers' Compensation Commission*, 2015 IL App (1st) 133233WC, ¶14, 35 N.E.3d 1129:

> By its own terms, *section 8(d)(1)* is subject to "limitations as to maximum amounts fixed in paragraph" 8(b) of the Act (820 ILCS 820 ILCS 305/8(b) (West 2006). *820 ILCS 305/8(d)(1)* (West 2006). In particular, maximum rates set forth in section 8(b)(4) of the Act (*820 ILCS 305/8(b)(4)* (West 2006)) have long been held applicable to wage-differential awards. (Citations omitted.) Effective July 20, 2005, the legislature amended *section 8(b)(4)*, adding express language concerning wage-differential awards and providing as follows: "For injuries occurring on or after February 1, 2006, the maximum weekly benefit under paragraph (d)1 *** shall be 100% of the [State AWW] in covered industries under the Unemployment Insurance Act." *820 ILCS 305/8(b)(4)* (West 2006); Pub. Act 94-277 (eff. July 20, 2005) (amending 820 ILCS 305/8(b)(4) (West 2004)).)

The maximum wage differential benefit for the May 1, 2006 date of accident is $822.20. Therefore, the Commission finds Petitioner established entitlement to wage differential benefits of $822.20 per week, beginning on September 9, 2016.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $952.00 per week for a period of 235 6/7 weeks, representing July 27, 2011 through January 29, 2016, 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 maintenance benefits in the sum of $952.00 per week for a period of 31 6/7 weeks, representing

18IWCC0134

January 30, 2016 through September 8, 2016, as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of permanent total disability benefits is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $822.20 per week commencing on September 9, 2016 and continuing for the duration of his disability, as provided in §8(d)1 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $1,890.00 for vocational services as provided in §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.

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

DATED: MAR 8 - 2018

L. Elizabeth Coppoletti

LEC/mck

O: 1/17/18

Charles J. DeVriendt

43

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BERKOWICZ, FRANCIS
Employee/Petitioner

Case# **06WC021336**

CITY OF CHICAGO
Employer/Respondent

18IWCC0134

On 12/5/2016, 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:

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0464 CITY OF CHICAGO CORP COUNSEL
ELIZABETH MANNION
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Francis Berkowicz
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 06 WC 021366

18IWCC0134

An *Application for Adjustment 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 **September 8, 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 **Petitioner's entitlement to vocational services**

FINDINGS

On **May 8, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$74256.00**; the average weekly wage was **$1,428.00**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$128,526.75** for TTD, **$0** for TPD, **$123,630.49** for maintenance, and **$0** for other benefits, for a total credit of **$252,157.24**.

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 $952.00 per week for 235-6/7 weeks, commencing July 27, 2011 through January 29, 2016**, as provided in **Section 8(b) of the Act.**

Respondent shall pay Petitioner **maintenance benefits of $952.00 per week for 31-6/7 weeks, commencing January 30, 2016 through September 8, 2016**, as provided in **Section 8(a) of the Act.**

Respondent shall pay Petitioner **reasonable and necessary vocational services of $1,890.00**, as provided in **Section 8(a) of the Act.**

Respondent shall pay Petitioner **permanent total disability benefits, commencing September 9, 2016, of $952.00/week for life**, as provided in **Section 8(f) of the Act.**

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment fund***, as provided in Section 8(g) of the Act.

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

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

Signature of Arbitrator

December 5, 2016
Date

DEC 5 - 2016

FINDINGS OF FACT

Petitioner was employed by Respondent as a hoisting engineer. His job requires him to operate heavy equipment such as grinders, pavers, cranes and graffiti removal trucks. This matter comes before the Arbitrator on remand from a Commission Decision, pursuant to Section 19(b), entered on November 21, 2011. Arbitrator Kane closed proofs on the §19(b) hearing on May 24, 2011. The provisions of the Commission's Decision, which are final, establish that Petitioner sustained a compensable accident on May 1, 2006 while working for Respondent. He felt a "pop" in his right knee while lifting a 50 lb bag of powder. The injury required multiple Orthovisc injections to Petitioner's right knee and ultimately led to a recommendation for a total knee replacement. The dispute over whether or not Respondent was liable for Petitioner's knee replacement surgery is what led to the Section 19(b) hearing. The Commission determined that Respondent was liable for this surgery. (ArbX 2)

Before the Commission issued its decision, Petitioner continued seeing his treating orthopedic surgeon, Dr. Craig Westin, on an intermittent basis. On September 19, 2011, Dr. Westin noted that Petitioner was experiencing left--opposite--knee problems "because it is seeing a lot more stress since the right knee has gotten worse lately." (PX 1, p. 32)

After the Commission issued its decision, Petitioner underwent a right total knee arthroplasty by Dr. Craig Westin on March 28, 2012. (PX 1, p. 74-75) Post-operative care was overseen by Dr. Westin and on August 9, 2012, he noted Petitioner's complaints of ongoing left knee pain. On September 20, 2012, Dr. Westin injected Petitioner's left knee with cortisone and noted that Petitioner's inability to work was due to the condition of both knees. (PX 1, p. 21-22) Petitioner testified that his left knee symptoms began in late 2008 or early 2009, but they did not rise to the level that required treatment until after his right knee replacement surgery.

On November 12, 2012, Petitioner was examined at the request of Respondent, pursuant to §12 of the Act, by Dr. Scott Sporer. (RX 4) Dr. Sporer diagnosed Petitioner with left knee tricompartmental degenerative

arthritis which, he felt, would require total knee arthroplasty in the future. Dr. Sporer did not believe that Petitioner's left knee symptoms were related to his accident at work, since they did not begin until nearly three years after the accident. (RX 4)

Dr. Sporer re-examined Petitioner at Respondent's request on August 28, 2013. (RX 4) At that time, Dr. Sporer felt that the condition of Petitioner's right knee had improved to the point at which he could return to work at medium duty with permanent restrictions of no kneeling, or repetitive bending or stooping. He felt that a hoisting engineer could work within these restrictions, and that Petitioner's right knee had reached MMI. Dr. Sporer noted that this release was not applicable to Petitioner's left knee, which he felt was unrelated to the accident. (RX 4)

On September 12, 2013, Dr. Westin opined that Petitioner's "left knee became quite a bit worse since the right knee was injured and then had subsequent surgery. In (his) opinion, the added stress on the left knee accelerated its decline. Westin considered the left knee condition to be an indirect event of his right knee problems which are work-related. (PX 1, p. 12)

Dr. Westin administered a number of Synvisc and cortisone injections to Petitioner's left knee throughout 2014. On August 5, 2015, Petitioner underwent a left total knee arthroplasty by Dr. Westin. Petitioner moved to Arizona in approximately November, 2015. He had owned a house in Arizona since 2005.

Petitioner began looking for employment as early as January, 2015 which was prior to his left knee replacement surgery. He continued to look for work after relocating to Arizona. In January, 2016, Petitioner met with Mark Kelman, a vocational counselor to whom he was referred by his attorney, and worked intermittently with Mr. Kelman in an effort to find employment. (PX 4, 5 &6)

The permanent work restrictions recommended by Dr. Westin were finalized in January, 2016: no lifting over 40 lbs, occasional standing and walking, no climbing, bending or twisting, and no working on uneven ground.

On April 18, 2016, Petitioner was examined at the request of Respondent, pursuant to §12 of the Act, by Dr. Joshua Jacobs. (RX 3) Dr. Jacobs felt that Petitioner should be limited to no lifting over 30 lbs, and no walking or standing for more than one hour per day. He did not feel that Petitioner could return to his duties as a hoisting engineer. He did not feel that Petitioner's left knee condition was related to his accident of May 1, 2006. (RX 3)

On April 27, 2016, Mark Kelman issued a vocational analysis in which he indicated that because Petitioner has no transferable skills to sedentary or light work and, because of Dr. Westin's permanent restrictions, Petitioner could be characterized as an "odd lot." Kelman noted that Petitioner had been seeking employment in Arizona since December of 2015 without success. At best, Kelman felt that Petitioner might qualify as a parking lot attendant with the ability to sit or stand as needed, and these jobs averaged $9.15 per hour. Kelman also characterized Petitioner as having put forth a good faith effort to find employment. (PX 4) Kelman is an experienced vocational rehab consultant, with a M.S. degree and C.V.E. and C.R.C. designations. (PX 3)

Petitioner continued looking for work. He produced records reflecting that he sought work without success from 233 prospective employers from January, 2015 through August, 2016. (PX 8-9) On August 31, 2016, Mark Kelman confirmed that Petitioner had continued looking for work, most recently as a parking lot attendant or telemarketer. (PX 5) Petitioner has not found employment. He has received no job offers.

Respondent did not offer Petitioner vocational services or any kind of a job. Petitioner was contacted by the Committee on Finance on April 18, 2014 and March 29, 2016 in order to set up a meeting with a DHR representative to attempt to facilitate return to work at Respondent. (PX 10 & 11) The meetings did not take place. Petitioner did not make any inquiries with Respondent regarding its Reasonable Accommodation Program. He was not aware of any City jobs available to him. He could not get a position through his union, due to the work restrictions that had been placed on him. Petitioner did not request vocational assistance while

he was living in Chicago. Respondent did not file a Vocational Assessment/Plan, as required by Rule 7110.10(a).

Respondent did obtain a Labor Market Survey, by Kari Stafseph, C.R.C., of Vocamotive. Stafseth concluded that Petitioner was employable, with a probable low wage range of $10.00-13.00 per hour and high range at $14.00-16.00. This would be for jobs in Chicago. There was no personal interview of Petitioner by Stafseth, so Petitioner's education and work history was not known. His keyboarding and computer skills was unknown as well. (RX 5)

Respondent paid Petitioner TTD and Maintenance Benefits related to this portion of the case from 7/27/2011 through 9/2/2016.

Petitioner testified that he currently walks with the aid of a cane, has an unsteady gait, is unable to kneel and is limited in his ability to walk or bend. He testified that his originally injured right knee is much more symptomatic than his left knee.

CONCLUSIONS OF LAW

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

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

It has already been determined by the Commission that Petitioner's right knee condition is causally connected to his accident at work. That finding is not subject to collateral attack. At issue, therefore, is whether Petitioner's left knee condition is also causally connected. After considering the evidence of record, the Arbitrator finds that it is.

Dr. Craig Westin has been Petitioner's treating orthopedic surgeon throughout the history of this case. Petitioner was referred to Dr. Westin by Respondent's clinic. Dr. Westin has observed the progression of the condition of both of Petitioner's knees since May 11, 2006. He has opined that the altered gait associated with

Petitioner's right knee injury (an injury sufficiently severe to have warranted a knee replacement) was sufficient to have aggravated the degenerative condition of Petitioner's left knee. The Arbitrator considers this opinion to be persuasive and it is the causation opinion that best comports with the evidence.

By contrast, Respondent's examining physicians conclude that Petitioner's left knee condition is not causally connected to his accident at work, but they neither analyze nor consider the question of an aggravation resulting of left knee osteoarthritis from an altered gait, favoring the right knee. The opinions of Dr. Sporer and Dr. Jacobs are not persuasive on the issue of causation.

Based on the foregoing, the Arbitrator concludes that Petitioner's current condition of ill-being relative to both knees (status post right knee arthroplasty, 3/28/2012 and status post left knee arthroplasty, 8/5/2015, with permanent work restrictions set forth above) is causally connected to the accidental injuries of May 8, 2016.

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 Parties stipulated that Petitioner was temporarily and totally disabled for the period from July 27, 2011 through August 27, 2013. At issue is the period beginning August 28, 2013. That is the date on which Petitioner was re-examined by Dr. Scott Sporer, who concluded that Petitioner had attained MMI on account of his accidental injury. Dr. Sporer limited his opinion to Petitioner's right knee because he felt that Petitioner's left knee condition was not causally connected to the injury. At the time of this report, Petitioner was still actively treating with Dr. Westin for his left knee and was unable to return to work. That treatment culminated in a total left knee replacement on August 5, 2015. Dr. Westin's final, permanent restrictions were issued on January 29, 2016. As is noted above, the Arbitrator has found that Petitioner's left knee condition is causally related to the injury.

Although Petitioner had begun looking for work one year prior to the imposition of permanent restrictions by Dr. Westin, those efforts continued after the permanent restrictions had been established. Petitioner's efforts to find employment, under the auspices of a certified vocational rehabilitation counselor,

continued until the arbitration hearing on September 8, 2016. Respondent did not provide Petitioner with vocational or job placement assistance. Respondent did not prepare and file a Vocational Plan. Petitioner's job search efforts, while not the best, are not found to be in bad faith. He tried (albeit unsuccessfully) to find full time employment within his restrictions.

Based upon the foregoing, the Arbitrator concludes that Petitioner is entitled to temporary total disability benefits for the 235 3/7 week period from July 27, 2011 through January 29, 2016 (the date of Dr. Westin's final restrictions); and that Petitioner is also entitled to receive maintenance benefits pursuant to Section 8(a) of the Act for the 31 6/7 week period from January 30, 2016 through September 8, 2016.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's bilateral knee condition has resulted in significant permanent restrictions. The lifting restriction of Respondent's Section 12 examiner (30 lbs) is actually more restrictive than that of the treating doctor (40 lbs). Petitioner is also limited in his ability to walk, stand, bend, kneel, climb and ambulate on uneven ground. These restrictions will not permit him to return to his job as a hoisting engineer.

Petitioner has also produced vocational evidence reflecting that he is an "odd lot" and evidence that he has engaged in a good faith, albeit unsuccessful, attempt to find work within his restrictions.

Respondent has produced a labor market survey reflecting various jobs that would be suitable for an individual with Petitioner's restrictions. (RX 5) The author of this report, Kari Stafseth of Vocamotive, admits that she had not met with Petitioner and had no information regarding his educational history, alternative skills, employment history, computer proficiency or other certifications. Petitioner testified that he lacks the skills and/or experience required for nearly all the jobs reflected in the labor market survey.

Petitioner did not make a formal demand for vocational rehabilitation services while he still resided in Chicago. Respondent did not comply with Rule 7110.10(a).

Once Petitioner established that he was unable to return to his usual and customary line of employment on account of his injuries, and once he further established that he had engaged in an unsuccessful good faith effort to find employment, the burden shifted to Respondent to demonstrate the availability of suitable work. This has not been done. Respondent's labor market survey merely lists a number of sedentary to light duty jobs, all of which require skills or experience which Petitioner lacks.

While the parking lot attendant position exists, and perhaps it is a viable job for Petitioner, Petitioner was unable to obtain placement in this job. As Kelman said in his report, these jobs are hard to obtain.

Based on the foregoing, the Arbitrator concludes that Petitioner is permanently and totally disabled pursuant to Section 8(f) of the Act.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent asserts a credit and reimbursement for benefits paid after Dr. Sporer's MMI finding of August 28, 2013. Based upon the Arbitrator's findings regarding causation and TTD/Maintenance above, the claim for reimbursement of lost time benefits is denied.

WITH RESPECT TO ISSUE (O), PETITIONER"S ENTITLEMENT TO VOCATIONAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Although Petitioner was referred to Mark Kelman by his attorney, it is clear that Kelman was not retained solely as an expert witness for the purposes of litigation. To the contrary, he met with Petitioner on several occasions, administered vocational testing, assisted him in crafting a resume and made return to work recommendations despite the initial conclusion that Petitioner was an "odd lot." (PX 4, 5, 7) Kelman spent a total of 18 hours assisting Petitioner in his quest to find employment. The services provided by Kelman to Petitioner are those contemplated to Section 8(a) of the Act as within Respondent's responsibility to provide necessary vocational services and Kelman's hourly rate of $105.00 is not unreasonable for those services.

Based on the foregoing, the Arbitrator concludes that Petitioner is entitled to have and receive from Respondent the sum of $1,890.00 for vocational services pursuant to Section 8(a) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angela Hobbs,
Petitioner,

vs.

NO: 14WC 12417

Collective Brands d/b/a;
Payless Shoes,
Respondent,

18IWCC0135

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 6, 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,700.00. 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: MAR 8 - 2018

Charles J. DeVriendt

Joshua D. Luskin

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CJD/rlc
049

DISSENT

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. [citations omitted]. 'In the course of employment' 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). "Arising out of" speaks to risk- is the risk encountered by the employee a risk incidental to the employment as not all injures suffered while at work are compensable. See *e.g. Brady v. Louis Ruffolo & Sons Construction Company*, 143 Ill. 2d 542, 552, 578 N.E.2d 921 (1991) ("This court has previously declined to adopt the positional risk doctrine, believing that the doctrine would not be consistent with the requirements expressed by the legislature in the Act"). "To satisfy this requirement it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Sisbro* at 203. I believe Petitioner has failed to prove she sustained an injury which arose out of and occurred in the course of her employment. Accordingly, I dissent.

Petitioner is employed by Respondent as a sales associate. T. 11. As part of her job duties at times, she deposits the prior day's revenues at the bank. T. 12. On the day in question, Petitioner completed the bank task, and upon exiting her vehicle in front of Respondent's premises, she slipped on ice. *Id.* These facts are not in dispute. Therefore, the threshold questioned presented is- whether Petitioner maintained her status as a traveling employee upon arrival in the parking lot. The matters of *Pryor v. Illinois Workers' Compensation Commission*, 2015 IL App (2d) 130874WC and *Allenbaugh v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150284WC are instructive.

In *Pryor*, claimant worked for a car hauler which required him to travel away from his employer's premises to deliver cars to dealerships. In performing this job, claimant was required to stay in hotels overnight. He would drive his personal vehicle with his overnight bag to employer's premises. On the date of the claimed accident, claimant prior to embarking to the employer's premises, loaded his personal vehicle with his suitcase and in so doing, injured his back. The Commission denied the claim, and the Appellate Court affirmed. *Pryor v. Illinois Workers' Compensation Commission*, 2015 IL App (2d) 130874WC.

In the court's decision, it reviewed the long-held principle that "[t]he general rule is that an injury incurred by an employee in going to or returning from the place of employment does not arise out of or in the course of the employment and, hence, is not compensable." *The Venture-Newberg-Perini, Stone & Webster v. Illinois Workers' Compensation Commission*, 2013 IL 115728, ¶ 16 (quoting *Commonwealth Edison Co. v. Industrial Commission*, 86 Ill. 2d 534, 537 (1981)). The court then discussed the common exception of a traveling employee, a traveling employee being "one whose work duties require him to travel away from his employer's premises" and noted an injury arises out of a traveling employee's employment if the employee is engaged in conduct which is reasonable and foreseeable when the injury occurs. *Pryor* at ¶ 20. As such, the court stated, "the threshold question in this case is: had the claimant embarked on a work-related trip at the time he was injured on July 21, 2008, or was he merely beginning his regular commute to his employer's premises at that time?" *Pryor* at ¶ 22. The court concluded claimant was not a traveling employee at the time of his injury finding "he was making a regular commute to a fixed jobsite as a necessary precondition to any subsequent work-related travel." *Pryor* at ¶ 29.

In *Allenbaugh*, claimant was a police officer whose job duties required him to travel up to 75% of his shift. On the date of the claimed accident, claimant was traveling to police headquarters to participate in mandatory training when he was involved in an automobile collision. The Commission denied the claim, and the Appellate Court affirmed. *Allenbaugh v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150284WC.

In its decision, the court again reviewed the long-held principle that injuries incurred traveling to or from work are generally not compensable but noting the traveling employee exception. *Allenbaugh* at ¶ 16. The court further stated "[c]ommuting is not encompassed by this doctrine" and commenting "he (appellant) cites no authority that holds that where an employee regularly drives as part of his job duties, his or her commute is brought within the scope of employment. Our research has uncovered no support for this proposition as well." *Allenbaugh* at ¶¶ 16-17.

In both *Pryor* and *Allenbaugh*, the claimants' jobs were such, at times, they would qualify as a traveling employee, but such status was not all-encompassing. In both *Pryor* and *Allenbaugh*, the claimants were injured during the normal commute to the employers' premises.

Such are the facts in the present matter. Petitioner was required to travel away from the employer's premises to effectuate the bank deposit. Petitioner completed the task and was on her normal commute when parking in the lot. As the court noted in *The Venture-Newberg-Perini, Stone & Webster v. Illinois Workers' Compensation Commission*, serious policy concerns are raised when the designation of a traveling employee status gives rise to benefits that are not normally afforded to like employees during their normal commute. 2013 IL 115728, ¶ 25. For example, in the present matter, if Petitioner is a traveling employee, her fall on ice would be deemed compensable as "where the street becomes the milieu of the employee's work, he is exposed to all street hazards to a greater degree that the general public." *Nee v. Illinois Workers' Compensation Commission*, 2015 IL App (1st) 132609, ¶ 26 (quoting *C.A. Dunham Co. v. Industrial Commission*, 16 Ill. 2d, 102, 111 (1959)). On the other hand, if Petitioner is merely commuting to work, the same fall on ice would be deemed not compensable absent Petitioner proving she qualified under one of two exceptions discussed in detail below.

Despite Petitioner's failure to qualify as a traveling employee, the inquiry does not end. As the court noted in *Illinois Bell Tel. Co. v. Industrial Commission*, "when an employee slips and falls, or is otherwise injured, at a point off the employer's premises while traveling to or from work, his injuries are not compensable." 131 Ill. 2d 478, 483-484 (1989) (quoting *Reed v. Industrial Commission*, 63 Ill. 2d 247, 248-49 (1976)). Two exceptions to this general rule exist: 1) when an employee falls in a parking lot maintained or controlled by the employer; or 2) when an employee is required to be at a place in fulfillment of her job duties, and the employee is exposed to a risk to a greater degree than the general public. *Illinois Bell Tel. Co* at 484. Neither exception applies.

Petitioner testified she was not required to park in any specific area of the lot. T. 13-14. Further anyone could park in the space in which Petitioner chose to park including customers. T. 14. There was no testimony as to the entity which owned or maintained the parking lot. The photographs offered into evidence document a strip mall with multiple stores including Respondent's. RX9. Petitioner testified employees from Rural King were shoveling snow that morning. T. 45. Petitioner testified Respondent neither required nor requested Petitioner perform snow removal. *Id.* From such evidence it would be mere speculation to find Respondent owned or maintained the parking lot. Additionally, Petitioner conceded Respondent did not control where she chose to park. As such the parking lot exception is not applicable.

The second exception is no more applicable. There is no testimony as to which entrance Petitioner was required to use. There is no testimony as to Petitioner's route for entry into the building, or more importantly, Respondent directed any such route. Petitioner testified she was free to park anywhere in the lot. T. 13-14. Additionally, there is no evidence Petitioner was exposed to a risk to a greater degree than the general public. Petitioner testified she and customers alike could park anywhere in the lot. T. 13-14. As the court noted in *Illinois Bell Tel. Co.*, "the mere fact that the duties take the employee to the place of injury and that, but for the employment, [s]he would not have been there, is not of itself, sufficient to give rise to the right to compensation." 131 Ill. 2d 478, 485-486 (1989) (quoting *Caterpillar*, 129 Ill. 2d at 63).

For the above stated reasons, I respectfully dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOBBS, ANGELA
Employee/Petitioner

Case# **14WC012417**

COLLECTIVE BRANDS D/B/A PAYLESS SHOE
Employer/Respondent

18IWCC0135

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:

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FAIRVIEW HTS, IL 62208

1682 HINSHAW & CULBERTSON LLP
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CHICAGO, IL 60601

18IWCC0135

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

Angela Hobbs
Employee/Petitioner

v.

Collective Brands d/b/a Payless Shoes
Employer/Respondent

Case # 14 WC 12417

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael K. Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **10/14/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner's average weekly wage was **$124.91**.

On the date of accident, Petitioner was **30** 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 for any medical benefits paid under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $19,612.00, as set forth in PX 1, 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.

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 **$124.91**/week for **23.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **12.5 % loss of the right hand.**

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

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

Signature of Arbitrator

8/24/16
Date

FINDINGS OF FACT

On December 10, 2013, Petitioner was employed as a part-time sales associate with Respondent. On the date of the injury, as she was exiting her vehicle in the parking lot adjacent to Respondent's premises returning from delivering an overnight deposit bag to the bank, she slipped and fell on ice, injuring her back, right wrist and elbow. Petitioner described the overnight bag as follows: "It's what we put the money in that—we don't take it that night because it might be dangerous, so we take it in the morning. We leave it in the safe overnight, and we take it to the bank in the morning." (T.12). She confirmed that she had performed this task prior to December 10, 2013, and indicated that she did not take any detours on her route from the bank to Respondent's premises on the date of accident. Petitioner confirmed that the parking lot in which she fell was open to the public, and there was not necessarily an area in which employees were instructed to park. She also testified that she was not operating a company owned vehicle, and Payless did not provide the shoes she was wearing at the time of the injury. Petitioner indicated during cross-examination that she parked her vehicle in a parking spot which was near the entrance to Respondent's storefront.

Prior to December 10, 2013, Petitioner sustained a right wrist fracture in 2003 as a result of a motor vehicle accident, but confirmed that since that time, she had not sustained any additional injuries to her right wrist. She also confirmed that she was under no active medical care and treatment with regard to her right wrist, and did not suffer from any symptoms or pain in her right wrist prior to December 10, 2013. Petitioner missed no time from work in the months leading up to the December 10, 2013 incident due to low back or right wrist pain.

Following the injury, Petitioner testified that she presented to her primary care physician, Dr. Knight, where she saw his physician's assistant, Megan, who asked her to return when Dr. Knight would be in the office. Petitioner's testimony is corroborated by the medical records, which indicate that Petitioner presented to Primary Care Group on December 10, 2013, and the following history was taken by Megan Hoffman, PA:

> The patient is a 30 year old female who presents with a work-related health problem. The problem is described as back strain. Date of occurrence: 12-10-13 @ 9:45 AM. The problem is a workers' compensation claim. Current symptoms include: back pain (neck strain, right elbow and right wrist). Note for "work related health problem:" patient was walking across the parking lot at Payless shoes and fell on the ice. (PX3, Primary Care Group, 12/10/13).

PA Hoffman also noted that Petitioner suffered from previous neck problems which had been treated with chiropractic medicine. *Id.* A review of Petitioner's symptoms revealed neck pain, as well as pain in her right elbow, right wrist, and low back. *Id.* On physical exam, rotation and movement of Petitioner's cervical spine was painful, and tenderness over the sacral vertebra and sacroiliac region were indicated. *Id.* Generalized tenderness in the right elbow and wrist were also documented. *Id.* Petitioner was diagnosed with muscle strains, prescribed 600 milligrams of Ibuprofen and advised to follow up in two days. *Id.*

Petitioner returned to Primary Care Group on December 11, 2013, and was seen by Dr. Stephen Knight. (PX3, Primary Care Group, 12/11/13). Dr. Knight took the following history:

> The patient is a 30 year old female who presents for a recheck of Work-related health problem. The problem is described as neck strain (Pt states that her neck hurts more than her back—she has been seeing a chiropractor and her neck and wrist and elbow. Painful range of motion). Date of occurred: slipped on ice at work yesterday. The problem is a workers' compensation claim. Current symptoms include: back pain. Note for "work related health problem:" she landed on her back and right elbow and wrist. *Id.*

On physical examination, Dr. Knight noted bruising on Petitioner's right elbow, neck pain and stiffness, as well as back pain. *Id.* Generalized tenderness to the right elbow and wrist were again noted. *Id.* Dr. Knight recommended x-rays of Petitioner's right elbow, wrist, cervical spine, and lumbar spine. *Id.* He also prescribed Cyclobenzaprine, and recommended that Petitioner ice the injured areas. *Id.* X-rays of Petitioner's right elbow and wrist were unremarkable, and did not reveal any evidence of fracture or arthritic changes. (PX4, Saline Valley Radiology, 12/11/13). X-rays taken of Petitioner's cervical and lumbar spine were also negative. *Id.*

Petitioner candidly acknowledged that she suffered from migraine headaches prior to December 10, 2013, which would provoke symptoms of dizziness. However, she testified credibly and without rebuttal that she did not experience a migraine headache on December 10, 2013, and that her fall was not caused by a migraine or dizziness. She confirmed: "when I did have a migraine, I stayed home from work." (T.26). The medical records are consistent with Petitioner's testimony.

Petitioner also presented to Dr. Bradley, who she had been seeing for neck pain prior to the accident, immediately following the injury on December 10, 2013. Dr. Bradley took the following history:

> Patient states, "I was working for Payless Shoes, I was coming back from taking a bank deposit at 9:45 a.m. and I got out of my truck and I slipped and fell on my backside and I caught myself with my left elbow. I had immediate neck pain and my right arm hurts. I went to see Dr. Knight but he wasn't there, so I saw his NP named Megan, she gave me Ibuprofen and she said my right wrist and back along with my elbow was injured, but my wrist isn't as bad now. I had some numbness in my right fingertips earlier. The pain is almost centered in my neck, but it does go to the left and right side and it is worse on the left side. My arm is sore and my neck is getting worse as time goes by (3:07 p.m. currently). I have lower back pain, it hurts in the center of the lower back, I fell straight down in my lower back, the pain is about the same in the lower back and it is not as bad as the neck area. I had to leave work early due to the pain. I have had two car wrecks in the past, but the pains were not long lasting and I came in here once in the past recently, but that is the only back problems that I have had. My past medical history reveals headaches and I take Effexor for anxiety." (PX5, Dr. Bradley, 12/10/13).

Dr. Bradley's assessment included "post traumatic fall at work that has caused a cervical and lumbar sprain/strain along with a right wrist sprain." *Id.* His plan of treatment included chiropractic manipulative techniques, as well as hot packs, and muscle stimulation. *Id.* He recommended continued follow up with a long-term goal of follow up for twelve (12) weeks. *Id.* The records reveal that Petitioner continued to follow up with Dr. Bradley from December 10, 2013 through April of 2014. Improvement in Petitioner's cervical and

lumbar spine conditions was noted, but on April 17, 2014, the last follow up with Dr. Bradley, it was indicated that Petitioner continued to suffer from right wrist pain worse with activity. (PX5, Dr. Bradley, 4/17/14).

On March 21, 2014, Petitioner presented to Dr. Aiping Smith upon referral from Dr. Bradley. (PX6, Dr. Aiping Smith, 3/21/14). Dr. Smith took the history of Petitioner's injury and noted continued symptoms of low back pain which were worse with standing, bending, lying down, and better with sitting or walking. *Id.* X-rays were also taken of Petitioner's lumbar spine, which revealed facet degenerative joint disease at L5-S1. *Id.* Dr. Smith diagnosed axial low back pain, and recommended an MRI to rule out a left pars fracture at L5. *Id.* Petitioner was advised to follow up after undergoing the MRI. *Id.*

An MRI of Petitioner's lumbar spine was performed on April 9, 2014, and revealed no evidence of a pars fracture and no disc protrusion or evidence of nerve root impingement. *Id.*

Petitioner retuned to Dr. Smith on May 1, 2014 following review of her lumbar spine MRI. It was noted that Petitioner's lumbar spine was doing quite well following chiropractic care and treatment, but that she still suffered from right wrist pain following the December 10, 2013 injury. Dr. Smith advised Petitioner to follow up as needed, and recommended a referral to Dr. Ahn for continued wrist pain. (PX6, Dr. Aiping Smith, 5/1/14).

On May 15, 2014, Petitioner came under the care and treatment of Dr. Steven Young upon referral from Dr. Bradley. (PX7, Dr. Young, 5/15/14). Dr. Young took the following history from Petitioner:

> Patient is a 30-year old right-hand dominant female who I am seeing in consultation today at the request of Michael Bradley for right wrist pain. The patient states that approximately 5 months ago, on 12/10/2013, she was in the parking lot of her work when she slipped on the ice. She states that she slipped backward and fell on her right wrist. She states that she had immediate pain in the wrist and went to her primary care where radiographs were taken; however, there were no fractures seen. The patient states that she had no further treatment for this. However, over the past 5 months, her pain has slowly worsened. She also states since injury, she started to have numbness and tingling in her fingers. She states that this is particularly worse when using the hand. She states that while she is cleaning her house by the end of the day, her hand is usually numbed. She denies having any numbness before the injury. She states at the time of the pain is bad enough that it awakens her at night. She denies having any steroid injections or bracing for the wrist. She does state that she had some manipulation of her wrists from the chiropractor; however, this did not give her any pain relief. *Id.*

On physical examination, tenderness on palpation of the ulnar aspect of the wrist was noted, as well as tenderness on palpation of the anatomical snuffbox. *Id.* Crepitus with ulnar and radial deviation of the wrist, as well as a positive Tinel's and median nerve compression test at the wrist were indicated. *Id.* Dr. Young also noted swelling over the dorsal aspect of the wrist. *Id.* Dr. Young recommended a nerve conduction study of Petitioner's right upper extremity as well as an MRI of her right wrist. *Id.* He advised that he would follow up with Petitioner after the completion of the nerve conduction study and MRI. *Id.* Approval was sought from workers' compensation. *Id.*

Dr. Young also authored an addendum note from May 15, 2015, specifically stating the following:

> Patient presents to the office today. She was seen in consultation today at the request of Dr. Michael Bradley. The consultation today was dictated by my PA, Lauren Houseright. I believe the patient has a potential TFC tear. She has primary ulnar sided wrist pain on the right side. We are going to get an MRI as the injury occurred 5 months ago and she has made no progress. We are also going to do a nerve conduction study. She tells me she has had numbness and tingling in the right hand ever since the injury and this is not getting better. She has a positive provocative sign for peripheral nerve compression today. We will see her back after these studies and discuss the results and plan our treatment. *Id.*

Petitioner underwent an MRI of her right wrist on July 14, 2014. (PX7, Orthopedic Institute of Southern Illinois, 7/14/14). The radiologist's impression was negative for any fracture or malalignment, and revealed thinning of the triangular fibrocartilage greatest radially, which was likely due to maceration and/or partial tear. *Id.* No full thickness tear was identified. *Id.* On the same date, Petitioner also underwent a nerve conduction study, which revealed evidence of a mild right median neuropathy at the wrist (carpal tunnel syndrome) affecting only the sensory components. (PX8, Dr. Newell, 7/14/14).

On July 22, 2014, Petitioner retuned to Dr. Young, who reviewed the results of Petitioner's right wrist MRI and nerve conduction studies. It was noted that Petitioner continued to suffer from symptoms of pain in her right wrist, especially at night. (PX7, Dr. Young, 7/22/14). After reviewing the MRI and nerve conduction studies, Dr. Young's impression was right carpal tunnel syndrome and right wrist pain. *Id.* He prescribed a wrist splint, as well as physical therapy, and a prescription for Voltaren gel. *Id.* He advised Petitioner to follow up in one month. *Id.*

Petitioner returned to Dr. Young on August 11, 2014 with no improvement in her symptoms following use of the wrist splint and physical therapy. (PX7, Dr. Young, 8/11/14). At that time, Dr. Young recommended a carpal tunnel release, as Petitioner had failed conservative treatment measures. *Id.*

On August 26, 2014, Petitioner returned to Dr. Knight's office and the following history was taken by Brooke Jackson, PAC:

> The patient is a 31 year old female who presents with a complaint of hand pain. The onset of the hand pain has been acute and has been occurring for 2 hours. The hand pain is characterized as a burning sensation (numbness and pain). The hand pain is described as being in the entire hand (right side). The symptoms have been associated with painful ROM (hand and wrist is painful and shooting pain into fingers). Note for "hand pain:" patient fell on hand in December and hurt wrist, still undergoing therapy and has been diagnosed with carpal tunnel by Dr. Young earlier in the summer. Unable to get carpal tunnel release done until work comp approves it.

On physical exam, decreased muscle strength of 4/5 was noted, as well as a positive Tinel's sign. *Id.* Assessment included carpal tunnel syndrome, and it was noted that Petitioner was currently under the care of

Dr. Young for this problem. *Id.* She was advised to call his office with an update on her condition, and she was also advised to take Ibuprofen. *Id.*

On March 4, 2015, Petitioner underwent a right carpal tunnel release. (PX10, Southern Illinois Orthopedic Center, 3/4/15). Intraoperative findings included moderate-to-severe thickening of the transverse carpal ligament. *Id.* Following surgery, Petitioner followed up with Dr. Young on March 18, 2015 and April 22, 2015, when she was ultimately released at maximum medical improvement. (PX7, Dr. Young, 3/18/15, 4/22/15). It was noted that although Petitioner was doing very well, she was still suffering from some tightness in the hand when extending her digits fully. *Id.*

Dr. Young testified by way of deposition, and his testimony was received into evidence as Petitioner's Exhibit 12. Dr. Young testified that he is board certified in the field of orthopedic surgery, and specializes in hand and upper extremity surgery. (PX12, Deposition of Dr. Young, p. 4). Dr. Young confirmed that he sees approximately 200-250 patients on a weekly basis, and performs on average thirty (30) surgeries per week, with six (6) to eight (8) of those surgeries consisting of carpal tunnel releases. *Id.* at 5. He estimated that he has performed approximately 4,000 carpal tunnel releases in his practice to date. *Id.* at 24. Dr. Young confirmed that the majority of his patients were referred through their primary care physician, and estimated that fifteen (15) percent of his practice involved treating individuals with work-related injuries or conditions. *Id.* at 5-6. He testified that he does not perform independent medical evaluations in his practice. *Id.* at 6.

Dr. Young confirmed that he took the history of Petitioner's December 10, 2013 injury, and performed a physical examination on May 15, 2014. *Id.* at 11. He confirmed that Petitioner had positive provocative testing for carpal tunnel syndrome in the form of a positive Tinel's and positive median nerve compression test, which is also referred to as a direct compression test. *Id.* at 11. Dr. Young verified that the direct compression test is typically the most specific and sensitive test on physical examination to detect carpal tunnel syndrome. *Id.*

Dr. Young testified that he believed Petitioner's injury on December 10, 2013 contributed to and aggravated the development of her right carpal tunnel syndrome, and explained the basis for his opinion as follows: "I think she was relatively asymptomatic prior to the injury. She had a traumatic event, and carpal tunnel developed following or shortly after the incident." *Id.* at 14. Dr. Young also confirmed that carpal tunnel syndrome can develop post traumatically "where the symptoms may develop even a few weeks after [the event] as the shearing stresses on the lining of the tendons in the carpal tunnel start to heal and scar tissue develops." *Id.* at 7-8. He also testified that the history Petitioner presented with, including immediate pain following the December 10, 2013 followed by the gradual development of numbness and tingling into her fingers was typical of an individual who had developed post-traumatic carpal tunnel syndrome. *Id.* at 15. Dr. Young further testified that his opinion was supported by the lack of prior symptoms evidenced in Petitioner's medical records and in her history, because "that would give more support to the single event as being a causative factor. No symptoms were evident prior to the injury, and they developed after the injury." *Id.* Dr. Young also confirmed that he identified moderate to severe thickening of the transverse carpal ligament during surgery, which supported his diagnosis of right carpal tunnel syndrome. *Id.* at 17. He testified that his diagnosis was further supported by her improvement following surgery. *Id.* at 18. Dr. Young also testified that he had reviewed Dr. Stiehl's independent medical examination and disagreed with Dr. Stiehl's conclusion that Petitioner was not suffering from carpal tunnel syndrome. *Id.* at 19.

Respondent had Petitioner examined pursuant to Section 12 of the Act by Dr. James Stiehl, whose deposition testimony was received into evidence as Respondent's Exhibit 2. Dr. Stiehl testified that he is a general orthopedic surgeon whose practice is comprised of approximately fifty (50) percent performing independent medical examinations. (RX2, p. 8). Dr. Stiehl testified that Petitioner was suffering from modest symptoms of early carpal tunnel syndrome in her right hand, but that under the AMA guidelines, her diagnosis would not constitute an actual condition of carpal tunnel syndrome. *Id.* at 16. When asked if he reached a conclusion with regard to the medical necessity of a carpal tunnel release to relieve the effects of Petitioner's condition, he indicated:

> Again, I did not find clinical findings consistent with the presence of a carpal tunnel syndrome. However, if a qualified physician in this case a hand surgeon, Dr. Young, decided that it was necessary if that's his choice and the patient agrees, then obviously he determines it's warranted. But I did not recommend it based on what I saw. *Id.* at 18.

Dr. Stiehl believed that Petitioner's BMI and female sex, as well as what he described as her "chronic neck and back pain" would be factors in the development of her carpal tunnel syndrome, but did not believe that the December 10, 2013 injury played any role whatsoever. *Id.* at 20. He also confirmed that he performed an AMA impairment rating, and provided a rating of zero percent impairment to her right elbow, right wrist, and with regard to carpal tunnel syndrome. *Id.* at 23-24.

Dr. Stiehl also testified that he prepared an addendum report after receipt of additional medical records, including the operative report dated March 4, 2015. When questioned as to how a surgeon identifies thickening of the transverse carpal ligament, he testified: "I would have to confess, I don't know." *Id.* at 26.

On cross-examination, Dr. Stiehl acknowledged that it had been approximately two (2) years since he had performed a carpal tunnel release, and at most, from 1981-1987, he performed approximately 20-30 per year. *Id.* at 29. He also testified that he currently performs up to eight (8) or nine (9) independent medical examinations on a weekly basis, which are at the request of insurance companies or employers 97-99 percent of the time, and that he sees approximately thirty-five (35) patients per week. *Id.* at 29-30. He also confirmed that he gives approximately one deposition per week, and charges $1,500.00 for a report and $1,000.00 per hour for his deposition. *Id.* at 30-31.

Dr. Stiehl testified that he believed Dr. Young to be a competent hand surgeon, and acknowledged that he did not review any medical records prior to December 10, 2013 indicating that Petitioner suffered from any symptoms of right wrist pain or carpal tunnel syndrome. *Id.* at 33-34. He also acknowledged that individuals can develop post-traumatic carpal tunnel syndrome after sustaining a direct trauma to the hand or wrist. *Id.* at 34. Dr. Stiehl also acknowledged that he was unaware Petitioner had findings of wrist tenderness in the emergency room on the same date of injury, December 10, 2013. *Id.* at 35. He also acknowledged that Dr. Bradley's notations of wrist pain beginning on December 10, 2013 were omitted from his reports. *Id.* at 36. He could provide no explanation for the omissions. *Id.* Dr. Stiehl also testified that he did not believe he performed a direct compression test, or a median nerve compression test, of Petitioner's right upper extremity on physical examination, and did not dispute that this was the most sensitive and specific test for diagnosing carpal tunnel syndrome. *Id.* at 37-38. He also testified that he typically defers to the neurologist or physiatrist

to interpret his or her own studies, and did not have any reason to dispute the interpretation of Dr. Newell in this case. *Id.* at 38-39. Dr. Stiehl ultimately conceded that it was possible that the December 10, 2013 injury either caused or aggravated the development of Petitioner's right carpal tunnel syndrome. *Id.* at 47-48.

With regard to the AMA impairment rating he performed, Dr. Stiehl acknowledged that in December of 2014, he was the only physician who had certified Petitioner to be at maximum medical improvement, and that a finding that an individual had reached MMI was a prerequisite to performing an AMA impairment rating. *Id.* at 41-42. On cross-examination, Dr. Stiehl acknowledged that an individual could experience significant activity limitations or participation restrictions in the absence of demonstrable impairment, and that impairment assessment is only one step towards assessing an individual's disability. *Id.* at 42. He further acknowledged that disability and impairment were two different concepts. *Id.* at 43. Dr. Stiehl further testified that other than the Quick-Dash questionnaire he asked Petitioner to fill out in his office, he had no knowledge of her hobbies or extracurricular activities and whether those would have been affected by her injury. *Id.* at 44.

Despite improvement following surgery, Petitioner testified that she still experiences symptoms in her right hand when exercising, especially when performing a push-up or any kind of yoga. (T.24). She explained that "it still feels like it's trying to come apart at the seam." (T.24). She also confirmed that she is unable to place a significant amount of pressure on her hand and wrist. (T.24). Petitioner also confirmed that she has less strength in her right hand, and also experiences difficulty when typing. (T.24-25).

CONCLUSIONS

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

In Illinois, to obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. *Sisbro, Inc. v. Industrial Comm'n,* 797 N.E.2d 665, 671 (2003). If the injury coincides with these definitions and is traceable to a definite time, place, and cause, then said injury is accidental within the meaning of the Act. *Laclede Steel Co. v. Indus. Comm'n*, 128 N.E.2d 718, 720 (Ill. 1955).

The concept of "in the course of employment" refers to the time, place and circumstances surrounding the injury. *Lee v. Industrial Comm'n,* 656 N.E.2d 1084 (1995); *Scheffler Greenhouses, Inc. v. Industrial Comm'n,* 362 N.E.2d 325 (1977). That is to say, for an injury to be compensable, it generally must occur within the time and space boundaries of the employment. *Sisbro, supra.* An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. *Orsini v. Indus. Comm'n*, 509 N.E.2d 1005 (1987). In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work *or* that he or she is exposed to the risk of injury to a greater degree than the general public. *Id.*

"An injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he [or she] 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. [Citations]. 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." *Caterpillar Tractor Co. v. Industrial Comm'n*, 541 N.E.2d 665 (Ill. 1989); *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003).

Courts have also developed two exceptions to the "general premises rule" in relation to parking lots: 1) where the employee has sustained injuries in a parking lot that is "provided by and under the control of" an employer; or 2) where the employee was required to be at the place where the accident occurred in the performance of his or her duties, and the employee was exposed to risk of injury to a greater degree than the general public. *Mores-Harvey v. Indus. Comm'n*, 804 N.E.2d 1086 (Ill. App. 3d Dist. 2004) (emphasis added). These are two separate and distinct exceptions; therefore Petitioner is not obligated to meet both of these requirements. *Id.* N.E.2d at 1090. For the reasons set forth below, the Arbitrator finds that Petitioner was exposed to a risk of injury to a greater degree than the general public, and has therefore met her burden of proof on the issue of accident.

In finding that Petitioner has met her burden of proof on the issue of accident, the Arbitrator relies on the cases of *Lindquist v. Metropolitan Water Reclamation District*, 08 IWCC 0492 (2008), and *Homerding v. Indus. Comm'n*, 327 Ill.App.3d 1050, 1068, 765 N.E.2d 1064, 262 Ill.Dec. 456 (1st Dist. 2002). In *Lindquist*, the Commission reversed the arbitrator's finding that the petitioner's accident did not arise out of her employment and awarded benefits. In that case, the claimant testified that as an accounting clerk, her duties were mostly sedentary in nature, but that she was also responsible for preparing deposit slips and depositing checks at her employer's bank, which was approximately 1 ½ blocks away from her employer's office. *Lindquist v. Metropolitan Water Reclamation District*, 08 IWCC 0492 (2008). She testified that she regularly traveled to the bank to make deposits two to three (2-3) times per week. *Id.* On one occasion, while walking to the bank to make deposits, she stumbled while walking up a driveway on the east side of a Crate & Barrel store, causing her to fall forward. *Id.* She attempted to break her fall with her hands and fractured one of her wrists. *Id.*

On review before the Commission, the petitioner argued that a claimant can prove the "arising out of" element by demonstrating either that she was performing a required or beneficial task or that she was subject to an increased risk of injury, and maintained that the Arbitrator erred in requiring her to prove both of these elements. *Id.* The Commission agreed and found that Petitioner's accident arose out of and occurred in the course of her employment with Respondent, as she was clearly engaged in a work-related activity at the time her injury occurred. *Id.*

While the Commission in *Lindquist* found it unnecessary to reach the issue of whether the petitioner was exposed to an "increased risk," it noted that the claim would also compensable under that analysis. *Id.* The Commission noted that the petitioner was regularly required to traverse the streets in order to make deposits on behalf of the respondent and was thus exposed to the risk of the "dip" in the driveway with greater frequency than members of the general public. The Commission noted that in *City of Chicago v. Industrial Commission*, 389 Ill. 592, 60 N.E.2d 212 (1945), the Supreme Court held that "where the proof establishes that the work of the employee requires him to be on the street to perform the duties of his employment, the risks of the street become one of the risks of the employment and an injury suffered on the street while performing his duty has a causal relation to his employment, authorizing an award." *Id.*

The Arbitrator also finds the case of *Homerding v. Industrial Commission*, 327 Ill.App.3d 1050, 1068, 765 N.E.2d 1064, 262 Ill.Dec. 456 (1st Dist. 2002) instructive. *Id.* In that case, the Appellate Court reversed the Commission's denial of benefits and found that the claimant's fall arose out of her employment because she "fell while working." *Id.* The claimant, a nail technician, had already arrived for work and proceeded to set up her work station when she realized she needed additional supplies, which were located in in her vehicle. *Id.* at 1068. As she walked out to her vehicle to retrieve the case, she slipped on ice in the parking lot while attempting to return to the salon. *Id.* In finding that the claimant sustained a compensable accident, the court stated: "It is clear that claimant fell while working, carrying out a task that was quite foreseeable and necessary to her job. Accordingly, her injury necessarily arose out of and in the course of her employment. Additionally, the risk of injury to which claimant was exposed was connected to her employment." *Id.*

The Court in *Homerding* also found that the claimant was exposed to a greater increased risk of injury than the general public, and in so finding, stated the following: "Claimant was required to park in the rear of employer's business on a lot employer financially contributed to maintain, and she needed certain supplies to perform her job. But for the demands of her job, she would not have needed to make a second trip to her car nor negotiate the ice between her car and the salon door while carrying a large case. Her risk of injury accordingly was greater than that of the general public." *Id.* at 1069.

Like the claimants in *Lindquist* and *Homerding*, Petitioner was clearly engaged in a work-related activity at the time she was injured, as she was returning from delivering the contents of the store's overnight bag to the bank when she slipped and fell on ice in the parking lot. For this reason alone, the Arbitrator finds that Petitioner met her burden of proof with regard to the issue of accident. However, the Arbitrator also finds that Petitioner was exposed to a greater risk of injury than the general public. Like the claimant in *Homerding*, but for the demands of Petitioner's job, she would not have made a second trip to and from her car nor would she have been required to negotiate the ice between her car and Respondent's premises a second time.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner met her burden of proof in establishing that she sustained accidental injuries which arose out of and in the course of her employment with Respondent.

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

Pursuant to Illinois law, accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is *a* causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003). [Emphasis original]. "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Indus. Comm'n*, 723 N.E.2d 846 (3d Dist. 2000). Employers are to take their employees as they find them. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *A.C. & S. v. Indus. Comm'n*, 710 N.E.2d 837 (1st Dist. 1999) citing *General Electric Co. v. Indus. Comm'n*, 433 N.E.2d 671, 672 (Ill. 1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); *see also Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977).

In this case, the Arbitrator finds the opinions of Dr. Young persuasive. Dr. Young confirmed that he specializes in caring for and treating patients with conditions of the hand and upper extremity, and has performed thousands of carpal tunnel releases throughout his career. Dr. Young's opinion and diagnosis is also supported by objective findings on physical examination, including a positive direct compression test, which he described as the most specific and sensitive test to identify carpal tunnel syndrome, as well as evidence of thickening in Petitioner's transverse carpal ligament found intraoperatively. Dr. Young's opinion that Petitioner's right carpal tunnel syndrome developed as a result of the December 10, 2013 injury is also corroborated by the medical records placed into evidence by both parties at trial, which fail to demonstrate any evidence of a pre-existing pathology or symptoms. The Arbitrator declines to rely on the opinions of Dr. Stiehl, who based his opinions on the AMA guidelines' threshold diagnosis for carpal tunnel syndrome. Dr. Stiehl likewise did not believe he performed a direct compression test on Petitioner in his office, and acknowledged that he did not know how to identify thickening of the transverse carpal ligament during surgery.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the December 10, 2013 injury.

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?

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n,* 691 N.E.2d 13 (2000). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001). The provisions relating to medical care are unlimited in time under the doctrine set forth in *Efengee Electrical Supply Co. v. Indus. Comm'n*, 223 N.E.2d 135 (Ill. 1967).

As Petitioner has met her burden of proof on the issues of accident and causation, the Arbitrator concludes that Petitioner's medical care and treatment has been reasonable and necessary to date and reasonably required to cure or relieve the injured employee from the effects of the injury.

Respondent shall pay reasonable and necessary medical services of $19,612.00, as set forth in PX 1, 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.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 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 Respondent submitted an AMA impairment rating pursuant to Section 8.1(a) which was performed by Dr. Stiehl. However, the Arbitrator notes that at the time Dr. Stiehl examined Petitioner and performed an AMA impairment rating, Petitioner had not yet undergone the carpal tunnel release with Dr. Young, and the only physician who had certified Petitioner to be at maximum medical improvement in December of 2014 was Dr. Stiehl. Dr. Stiehl also acknowledged during his deposition that finding an individual to be at MMI was a prerequisite to performing an AMA impairment rating. (RX2 at 41-42). On cross-examination, Dr. Stiehl acknowledged that an individual could experience significant activity limitations or participation restrictions in the absence of demonstrable impairment, and that impairment assessment is only one step towards assessing an individual's disability. *Id.* at 42. He further acknowledged that disability and impairment were two different concepts. *Id.* at 43. Dr. Stiehl further testified that other than the Quick-Dash questionnaire he asked Petitioner to fill out in his office, he had no knowledge of her hobbies or extracurricular activities and whether those would have been affected by her injury. *Id.* at 44. The Quick-Dash form is a generic form substantially lacking in substance and detail. Dr. Stiehl provided a rating of zero percent impairment to her right elbow, right wrist, and with regard to carpal tunnel syndrome. *Id.* at 23-24. However, impairment does not equal disability. The impairment rating is part of the determination for permanent partial disability benefits, but is not the sole or main factor. The Arbitrator therefore gives *little* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner testified that she voluntarily resigned her employment with Respondent shortly after her injury, and is presently a homemaker. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that at the time of her injury, Petitioner was thirty (30) years old, and had one (1) dependent child. Due to her young age, Petitioner may reasonably be expected to live with her symptoms for the duration of her life expectancy, which is a significant number of years. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there 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 the Petitioner was a credible witness. The medical records of Dr. Young corroborate Petitioner's testimony with regard to continued symptoms in her right hand. Specifically, Dr. Young's final follow up visit with Petitioner documented tightness in Petitioner's hand when attempting to extend her digits fully. Further, Petitioner's continued symptoms were confirmed by her testimony at trial. Specifically, she testified that she still experiences symptoms in her right hand when exercising, especially when performing a push-up, or any kind of yoga. Petitioner explained that "it still feels like it's trying to come apart at the seam." She also confirmed that she is unable to place a significant amount of pressure on her hand and wrist. Petitioner has less strength in her right hand, and also experiences difficulty when typing. Further, the Arbitrator notes that the medical records are void of any indication that Petitioner is magnifying her symptoms or malingering in any way. 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 hand pursuant to §8(e) 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

ERIC RHEINECKER,

Petitioner,

vs.

NO: 12 WC 20543

KILIAN CORPORATION,

Respondent.

18IWCC0136

DECISION AND OPINION ON REVIEW

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

The Commission affirms the decision of the Arbitrator with regards to the award of permanent total disability under an odd-lot theory, however, clarifies the burden of proof standard cited by the Arbitrator. The Illinois Appellate Court clarified that an employee seeking "odd-lot status" must do more than make a *prima facie* case to shift the burden to the employer. *Lanter Courier v. Industrial Comm'n*, 282 Ill.App.3d 1, 6-7 (1996). With respect to the burden of production, the employee must initially establish by a preponderance of the evidence that (s)he falls within the "odd-lot" category. *See Valley Mould & Iron Co. v. Industrial Comm'n*, 84 Ill.2d 538, 547 (1981). Only where an employee proves by a preponderance of the evidence that he falls into the odd-lot category does the burden of production shift to the employer to demonstrate that the employee is employable in a stable labor market and that such a market exists. Whether the parties satisfy their respective burdens are questions of fact. In deciding issues of fact, it is the function of the Illinois Workers' Compensation Commission to determine the weight to be given to the evidence, judge the credibility of the witnesses, and resolve conflicting medical evidence. *City of Chicago v. Ill. Workers' Comp. Comm'n*, 373 Ill.App.3d 1080, 1092 (2007) *citing Boyd Electric v. Dee*, 356 Ill.App.3d 851, 860-61 (2005). Petitioner met his burden of

18IWCC0136

proof by the preponderance of the evidence that he fell into the odd-lot category for permanent total disability benefits. As such, the burden shifted to Respondent which failed to establish that suitable work was available.

The Award of the Arbitrator is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $729.32 per week for life, commencing April 28, 2016, as provided in §8(f) of the Act, for the reason that the injuries sustained caused permanent and total disability.

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 §8(g) 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: MAR 8 - 2018

Charles J. DeVriendt

CJD/dmm
O: 013118
49

Joshua D. Luskin

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RHEINECKER, ERIC
Employee/Petitioner

Case# **12WC020543**

KILIAN CORPORATION
Employer/Respondent

18IWCC0136

On 9/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1053 JOSEPH L SAMUELSON
5111 W MAIN ST
BELLEVILLE, IL 62226

1454 THOMAS & PORTELA
ROBERT HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

18IWCC0136

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

ERIC RHEINECKER
Employee/Petitioner

v.

KILIAN CORPORATION
Employer/Respondent

Case # **12** WC **20543**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 27, 2016**. By stipulation, the parties agree:

On the date of accident, **November 15, 2011**, 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 **$56,886.96**, and the average weekly wage was **$1,093.98**.

At the time of injury, Petitioner was **41** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$169,962.12** for TTD and maintenance, **$0** for TPD, and **$0** for other benefits, for a total credit of **$169,962.12**.

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 and total disability benefits of **$729.32** per week for life, commencing **April 28, 2016**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

RULES REGARDING APPEALS Unless a 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 20, 2016
Date

ICArbDecN&E p.2

SEP 29 2016

STATEMENT OF FACTS

Petitioner, a 41 year old laborer for the Respondent performing road construction, has spent essentially his entire work life performing heavy manual labor. For the 15 years preceding his 11/15/11 injury, he worked out of Laborers Local 670. During the three months immediately preceding his accident, he worked specifically for the Respondent performing road construction.

On 11/15/11 the Petitioner was working on a road/bridge project. As part of his duties, he was required to manually lift heavy (200-300 pounds) construction forms. As he and a co-worker were carrying a form, Petitioner stepped down approximately 18", his leg gave way and he landed on his knees. Medical records reflect that he felt and heard a pop in the right hip area. (Px11). He testified that his body twisted, as he held onto the form to avoid putting all the weight on the co-worker, and he immediately began to experience pain in his low back, right hip and groin. He reported the incident to his supervisor and was told to stay on the job site, but to avoid any further work. Later that day, Respondent's safety supervisor arrived and told the Petitioner to go home and seek medical care if he felt it necessary.

Throughout the evening of the 15th and into the next morning, Petitioner's condition worsened to the point that he felt he required medical care. He initially went to his family physician, Dr. Ahmed, and was immediately referred to Dr. Piontek. Dr. Piontek prescribed physical therapy, but during the first session, Petitioner experienced a spontaneous loss of bladder control and therapy was suspended. Petitioner was advised to see Dr. Purvines for orthopedic consultation. His medical records reflect that the Petitioner reported additional instances of bladder control issues.

On 1/3/12, Dr. Purvines opined that Petitioner, in addition to injuring his right hip, had sustained an L5-S1 disc herniation. When a course of conservative care failed to significantly improve Petitioner's symptoms, Dr. Purvines recommended a lumbar fusion. Both Respondent and Petitioner felt a second opinion was advisable so arrangements were made for Petitioner to be seen by orthopedic surgeon Dr. Raskas.

After examination and a review of various diagnostic studies, Dr. Raskas corroborated Dr. Purvine's diagnoses. As to his hip injury, Dr. Raskas referred Petitioner for specialized care and treatment, while he continued to treat Petitioner's lumbar spine. (Px1).

Based upon his diagnoses and Petitioner's failure to improve with conservative care, and following a discogram (Px15), Dr. Raskas felt Petitioner was a surgical candidate. He proposed either a lumbar fusion or a disc replacement at the L5-S1 disc level. After discussing these options with Petitioner, it was decided Petitioner would undergo the disc replacement surgery. Respondent authorized this course of treatment. (Px1).

On 8/24/12, Dr. Raskas performed a complete L5/S1 discectomy with decompression and total disc replacement. (Px5).

With regard to the right hip, Dr. Nunley diagnosed severe traumatic osteoarthritic changes of Petitioner's hip which he felt were directly related to Petitioner's 11/15/11 accident. After initially trying intra-articular injections, which provided only temporary relief, Dr. Nunley recommended a total right hip replacement. On 1/13/13 the Petitioner underwent a total right hip arthroplasty. (Px2 & Px6).

Post-surgical care, including therapy, medication and injections, were performed with regard to both surgeries. Unfortunately, the Petitioner testified that he did not recover well from his surgeries. While his back pain appears to have improved, he began to develop increased radicular symptoms. This caused a severe loss of feeling and strength in his right leg and foot. Eventually, he required the use of a cane to ambulate and other orthopedic devices to assist him with performing the requirements of his everyday activities. It should be noted that an EMG test was negative for radiculopathy. Petitioner was referred for pain management. Dr. Thom has attempted a multitude of modalities, but all have failed to significantly improve his condition. The Petitioner last saw Dr. Feinberg on 7/31/14, and the doctor recommended a lumbar CT scan and L4/5 epidural injection. The last note of Dr. Thom on 2/26/16 indicated the Petitioner continued to have bilateral low back pain and refilled his Oxycontin prescription. (Px1, Px3 and Px12).

Recommended by Dr. Raskas, a 5/28/13 Functional Capacity Evaluation (FCE) was performed, and reflected that the Petitioner was limited to activities at the light physical demand level. (Px13).

Both Dr. Raskas and Dr. Nunley felt Petitioner was permanently unable to return to his former occupation and required some significant limitations on his physical activities. In addition, ongoing pain management treatment with Dr. Thom was recommended. Dr. Raskas' final report of 6/14/13 indicated that while the Petitioner's FCE therapist found he was capable of work at the light physical demand level, he believed "in (his) experience this patient is going to do much better in a sedentary demand level occupation." He issued the following restrictions:

no lifting over 25 pounds, no repetitive lifting/bending activity, no ladder climbing, no repetitive stair use and the ability to frequently change positions as needed. Dr. Raskas also noted that given Petitioner's pain level, it would be challenging, though not impossible, for him to work an 8 hour day even in a sedentary occupation. At the last visit with Dr. Nunley on 6/27/13, the doctor issued permanent restrictions of no lifting over 25 pounds, and the avoidance of kneeling, squatting and twisting. He did note that while the restrictions were permanent, the Petitioner still had some room for improvement of his condition with therapy. (Px1 & Px2). The Petitioner's last therapy note from Brefield PT on 11/27/13 reported 6.5 out of 10 stabbing lumbosacral pain into the right hip and groin, and he was discharged with a home exercise and pool program. (Px13).

The Petitioner was evaluated by Dr. Stiehl at the request of the Respondent on 4/6/15. Following exam and review of the Petitioner's medical records, Dr. Stiehl opined that the Petitioner had sustained a low back strain on the date of accident, and that it was not apparent that the Petitioner had aggravated a right hip condition given x-ray and MRI films were within normal limits and any degenerative arthritis that existed was mild at the worst. He stated that the Petitioner had reached maximum medical improvement and needed no further treatment. He further opines that the Petitioner would need typical restrictions for a spine fusion and hip replacement: no lifting over 25 pounds; limited stooping, bending and twisting; no sitting for more than 2 hours at a time and no standing/walking for more than 2 to 4 hours per day. (Rx1).

After the completion of the FCE, Petitioner began a job search. For the past three plus years, Petitioner testified that he had unsuccessfully applied for over 1,000 positions. (see Px21, job search records from 8/12/13 to 4/11/16). On 9/28/15, the Petitioner underwent a vocational assessment with Blaine Rehabilitation Management. Following an extensive evaluation summarizing Petitioner's physical restrictions, his educational background, his work history and his vocational/intellectual capacities, Ms. Blaine concluded that the Petitioner was unable to return to work as a construction laborer or any other job similar to his past work history based on the FCE and the opinions of his treating physicians. Based on Dr. Raskas' indication that Petitioner was likely limited to the sedentary level, Ms. Blaine opined that the Petitioner did not have the transferrable skills to obtain work at the sedentary level. She noted he had a learning disability and difficulty with reading that would eliminate him from many such job titles. Further, he had no experience with computer applications or office-type work. She indicated that given the Petitioner had been out of the labor market for over four years, that he had a failed job search despite contacting approximately 700 employers over three years (noting most of these were in person), and his medication usage, she did not believe a stable labor market existed for the Petitioner, and that he would have a tough time being chosen over other candidates in a competitive work environment. (Px4). Despite this, the Petitioner has continued his job search since that time but has remained unsuccessful.

The parties have stipulated that the Respondent has paid the Petitioner all temporary total disability and maintenance benefits that were due and owing through the date of hearing, and this is supported by the stipulated credit to the Respondent in the Request for Hearing. In addition, the parties have stipulated that the Respondent has paid, or will pay, (see the stipulation of the parties and Pet. Ex. #20), pursuant to the Medical Fee Schedule, all of Petitioner's causally related medical expenses.

Petitioner testified that he currently suffers the following effects from his 11/15/11 accident:

1) disabling low back pain — which severely affects the range of motion of his spinal column;

2) radiating pain in his right leg which extends to his right foot and in his left leg which extends to his left knee;

3) numbness of the dorsal aspect of his right foot;

4) feelings of pin pricks in the plantar aspect of his right foot;

5) severe loss of strength/use of his right leg, for which he uses a cane to ambulate; and,

6) pain/discomfort from the right hip extending into his groin.

These conditions make the performance of the Petitioner's everyday activities very difficult. He testified that he can only sit/stand for 15-20 minutes at a time. When sitting, he has to change positions or he will develop severe back pain. If standing for longer than 15 minutes, his right leg will start to give way and he will lose his balance. He can only drive for approximately 40 minutes or his back and leg pain severely increases and his right foot becomes so numb he cannot feel the car pedals. His back and leg discomfort cause him difficulty with sleeping through the night, and he testified he is only able to sleep 3-4 hours at a time despite his use of Ambien. As a result, he usually lies down for short naps in the afternoon. Petitioner testified he has difficulty performing even basic everyday activities, such as putting on his socks and shoes. Most days, he requires the help of his son to dress himself. In addition to the aforesaid Ambien, Petitioner takes multiple prescription medications to help him cope with his continuing symptomatology (see Px22).

The Arbitrator notes that, subsequent to the closing of proofs, the parties stipulated to the submission of an amended Request for Hearing form, which the Arbitrator allowed to be included as part of the record in Arbitrator's Exhibit 1. The parties indicated that the purpose of the amendment was to correct the amount of credit attributable to Respondent. Also attached as part of Arbitrator's Exhibit 1 is a file stamped substitution of attorneys form verifying the Petitioner's attorney's representation in this matter.

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

As a result of this undisputed accident, the Arbitrator finds that the Petitioner has suffered serious and permanent injuries to the extent that he is permanently and totally disabled as set forth within Section 8(f) of the Illinois Workers' Compensation Act. Based on this finding, there is no need to analyze this case with regard to the five factors as set forth in Section 8.1b of the Act. As indicated in Section 8.1b, the Section is applicable to the determination of permanent partial disability, not permanent total disability. In this case, Section 8(f) of the Act is applicable.

The Petitioner was provided with consistent permanent work restrictions by Dr. Raskas, Dr. Nunley and Dr. Stiehl. The imposition of these permanent restrictions is supported by both the fact the Petitioner has undergone double anatomic replacement surgeries, including both an L5/S1 artificial disc and a total right hip, as well as the FCE findings. It is clear based on any and all of the indicated permanent restrictions that the Petitioner is unable to return to his regular job, which was at the heavy to very heavy work level, as a construction worker.

The Petitioner has proven entitlement to permanent total disability benefits via the odd-lot theory.

Under this theory, an employee is totally and permanently disabled when he "is unable to make some contribution to the work force sufficient to justify the payment of wages." (*Ceco Corp. v. Industrial Comm.*, 95 Ill.2d 278, 447 N.E.2d 842, 69 Ill.Dec. 407 (1983)). Pursuant to *Ceco Corp.*, the claimant does not need to be reduced to total physical incapacity before a permanent total disability award may be granted. A claimant can prove that he is totally disabled when he is incapable of performing services except those for which there is no reasonably stable market (citing *A.M.T.C. of Illinois, Inc. v. Industrial Comm.*, 77 Ill.2d 482 (1979)).

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. In making this determination, a claimant's employment potential, his age, training, education, and experiences should be taken into account. *Id.*

In considering the propriety of a permanent and total disability award, the Illinois Supreme Court stated in *Valley Mould & Iron Co.*:

"Under *A.M.T.C.*, if 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 (2 *A. Larson, Workmen's Compensation* sec. 57.51, at 10-164.24 (1980)), then the burden shifts to the employer to show that some kind of suitable work is regularly and continuously available to the claimant (2 *A. Larson, Workmen's Compensation* sec. 57.61, at 10-164.97 (1980))." *Valley Mould & Iron Co. v. Industrial Com.* (1981), 84 Ill.2d 538, 419 N.E.2d 1159, 50 Ill.Dec. 710 (1981).

In this case, the Petitioner presented sufficient evidence to support a claim for permanent total disability. All three noted physicians (Dr. Raskas, Dr. Nunley and Dr. Stiehl) issued very similar restrictions, so there is not much discrepancy in what the Petitioner can and cannot do, and there is a valid FCE which further supports the restrictions. The Petitioner testified to significant persistent pain and debilitating symptoms. Of note to the Arbitrator, Dr. Raskas also questions the Petitioner's ability to perform full time work even in the sedentary category, and Dr. Raskas initially had questioned the Petitioner's symptoms as possibly being magnified after the initial examination. The Arbitrator believes this enhances the credibility of the opinion of Dr. Raskas to some degree with regard to his conclusions regarding the Petitioner's abilities.

While the Petitioner is still relatively young with regard to his work life, the evaluation of Ms. Blaine revealed that the Petitioner has a learning disability, and that his basic scholastic skills are at the 7th grade level or below. The report indicates the difficulties the Petitioner experienced in getting started both in the career he was in at the time of the injury, as well as his time with the military Seabees. His work history appears to have been almost exclusively in the area of manual labor. The Arbitrator notes with interest Ms. Blaine's opinion that, even if a job could be found within his restrictions, the Petitioner would have difficulty performing them for a full 8 hours (per Dr. Raskas), and would have difficulty with many sedentary jobs in office environments due to his educational level, and thus would struggle in a competitive labor market when vying for jobs against other candidates. The failed job search certainly would appear to support this as well.

On their face, the work restrictions themselves don't appear to necessarily prevent the Petitioner from obtaining any employment whatsoever. However, for the reasons noted above, along with what appears to be a fairly extensive unsuccessful search for employment by the Petitioner over the course of several years, the Arbitrator finds that the Petitioner has shown that there is no suitable employment available to him within a stable labor market. As noted by Ms. Blaine, while he may be able to do something, it appears that his ability to enter a stable labor market that involves competition from workers who do not carry his significant limitations is extremely unlikely.

Based on the Arbitrator's finding that the Petitioner met his initial burden of proof concerning his disability, it became the Respondent's burden to prove that suitable employment was reasonably available. This burden was not met here, as the Respondent did not sufficiently establish the availability of any such suitable employment.

STATE OF ILLINOIS)
) SS.
COUNTY OF Winnebago)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald E. McFadden,
Petitioner,

vs.

NO: 07WC 56624

18IWCC0137

Cloisters of Forest Hills Corp,
Respondent.

DECISION AND OPINION ON REVIEW

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

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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $26,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 8 - 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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CJD/rlc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McFADDEN, RONALD E
Employee/Petitioner

Case# **07WC056624**

10WC049141

CLOISTERS OF FOREST HILLS CORP
Employer/Respondent

18IWCC0137

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:

0529 TUITE LAW
GREGORY E TUITE
119 N CHURCH ST SUITE 407
ROCKFORD, IL 61101

1408 HEYL ROYSTER VOELKER & ALLEN
LYNSEY A WELCH
120 W STATE ST 2ND FL
ROCKFORD, IL 61101

18IWCC0137

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Ronald E. McFadden
Employee/Petitioner

v.

Cloisters of Forest Hills Corp.
Employer/Respondent

Case # 07 WC 56624

Consolidated cases: 10 WC 49141

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 **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **January 12, 2017**. By stipulation, the parties agree:

On the date of accident, **March 17, 2006**, 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 **$40,480.96**, and the average weekly wage was **$778.48**.

At the time of injury, Petitioner was **52** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$10,898.58** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$10,898.58**.

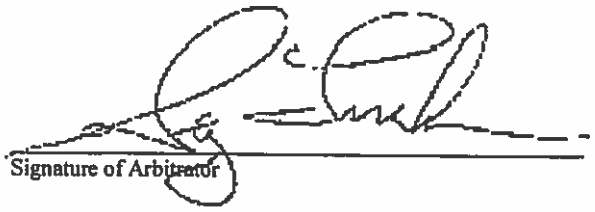
After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of $467.09/week for a further period of 79.9 weeks, because the injuries sustained caused **15% loss of use of the right arm, 12.5% loss of use of the right hand,** and **2.5% loss of use of the left arm** as provided in Section **8(e)** of the Act, and caused **2% loss of use of the whole person** as provided in Section **8(d)2** of the Act.

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

March 6, 2017
Date

ICArbDecN&E p.2

MAR 8 - 2017

Statement of Facts

This matter was heard in conjunction with consolidated case 10 WC 49141 (accident date July, 6, 2010). A single record was prepared, but the Arbitrator has issued separate decisions. A petition for fees by a former attorney is pending. No evidence concerning fees was presented, and the Arbitrator makes no findings with respect to the fee petition.

Petitioner Ronald McFadden testified that he was employed by Respondent Cloisters of Forest Hills as the maintenance supervisor for 11 years. He had previously worked for Beacon Hill apartments and as a self employed plumber. Respondent is a complex of 144 apartments on 14 acres. His duties for Respondent included snow removal, renovation and maintenance of the buildings including the boilers and clearing the land. This required cutting trees, using a chainsaw and chipper. Petitioner testified that he began developing symptoms in his hands and arms. Petitioner admitted a job analysis and video of certain duties as Petitioner's Exhibits 16 and 17.

Petitioner first saw Dr. Gander at Swedish American Medical Group on March 11, 2006 with complaints of numbness and tingling in the right arm with some aching. Dr. Gander scheduled an EMG (PX 12). The EMG/NCV was performed on March 17, 2006. Petitioner reported complaints of numbness and tingling in both hands. He notes that he does a lot of manual activities for work. The EMG impression was bilateral severe median nerve entrapment neuropathies, severe left cubital tunnel, possible cervical radiculopathy on the right side at C5-6 and C6-7. Dr. Rozman suggested probable carpal tunnel surgery, conservative treatment for the cubital tunnel and further work up for the cervical spine (PX 1).

Petitioner was referred to Dr. Lyddon. He was seen on April 19, 2006. Petitioner reported a history of cutting trees on July 4, 2004 and developing pain in his right elbow and subsequently numbness in the right hand. He notes some minimal numbness into the left small finger. Dr. Lyddon notes Petitioner did not have carpal tunnel or left ulnar neuropathy despite the electrical findings. He recommended a cervical MRI to rule out cord or root compression (PX 1). The MRI performed May 15, 2006 noted multilevel disc disease. Petitioner was referred for neurosurgical evaluation (PX 1).

Petitioner saw Dr. Todd Alexander on June 19, 2006. He complained of pain in the neck and right shoulder and numbness and tingling in the right hand and arm. Dr. Alexander's impression was symptoms consistent with right sided C5-6 and C6-7 disc protrusions and spondylosis causing radicular symptoms. He recommended conservative care. He notes a "double crush" type syndrome. Petitioner returned on September 22, 2006. He had undergone physical therapy with traction. He reported his neck was significantly improved. His complaint was numbness radiating down the ulnar aspect of his forearm and involving the fourth and fifth digits of his right hand. Petitioner was working full duty. Dr. Alexander noted he is doing well. Petitioner was going to take an expectant approach to his symptoms (PX 2).

Petitioner saw Dr. Gander on March 5, 2007 for a flare up of right wrist pain after shoveling snow (PX 12). Petitioner saw Dr. Gray on August 29, 2007 for right arm pain. He noted numbness for 2 years with increasing trouble since the spring. Petitioner reported constant pain from elbow to neck and numbness and tingling into the fourth and fifth fingers. Dr. Gray stated that an updated MRI of the cervical spine showed a lot of arthritis but no herniated discs. Petitioner was seen by Dr. Roh on January 10, 2008. He stated that Petitioner's symptoms do not emanate from the neck or shoulder. He stated the MRI noted congenital stenosis with multilevel disc protrusions, but no evidence of severe compression. He diagnosed a combination of lateral

epicondylitis and cubital tunnel syndrome and recommended a repeat EMG (PX 3). The EMG/NCV performed February 21, 2008 includes complaints of several years of shoulder and elbow pain as well as numbness and tingling in the small digits in the right arm. Petitioner attributes it to working in a wooded area cutting trees. The EMG/NCV interpretation was mild bilateral ulnar neuropathies at the wrist and moderately severe bilateral median neuropathies at the wrist (PX 3).

Petitioner saw Dr. Korcek on referral from Dr. Roh on March 10, 2008 for complaints of right arm pain due to cutting trees for his job in 2004 and 2005 after a windstorm. He noted Petitioner was working his regular job. Dr. Korcek examined the right hand and arm, reviewed the EMG, and took x-rays. He diagnosed bilateral carpal tunnel greater than distal ulnar tunnel, right sided symptoms more pronounced. He provided an injection into the right carpal tunnel (PX 4). Petitioner was placed on restrictions of no repetitive flexion and extension (PX 23). Petitioner began physical therapy on April 8, 2008. He reported that his right hand has been bothering him more than his left, but both have caused him pain for the last year or so. Petitioner advanced symptoms of right lateral epicondylitis on May 14, 2008, and received an injection into the elbow. On June 18, 2008, Dr. Korcek noted improved right sided symptoms. Left sided symptoms are minimal. On August 18, 2008, Petitioner's main complaint was pain in the right elbow. Dr. Korcek injected the right carpal tunnel and lateral epicondyle (PX 4). Petitioner was restricted to activity as comfort allows (PX 23). On October 28, 2008, Petitioner reported that the injections were not as beneficial as the first ones. Dr. Korcek recommended surgery. The surgery was scheduled for December 4, 2008, but Petitioner suffered a coronary on November 28, 2008 and the surgery was cancelled pending his recovery from his heart condition (PX 4).

On April 1, 2009, Petitioner returned to Dr. Korcek to reschedule his surgery. He reported that he is working his regular job part time. His symptoms are about the same. Dr. Korcek diagnosed right carpal tunnel, right distal ulnar tunnel, and right lateral epicondylitis. Petitioner continued follow up and work per the cardiologist restrictions at his visit with Dr. Korcek on August 24, 2009. Dr. Korcek cleared Petitioner for surgery on November 06, 2009. On November 13, 2009, Petitioner underwent right carpal tunnel open release, right ulnar nerve decompression, and right lateral epicondylar debridement (PX 4).

Petitioner proceeded with post operative care with Dr. Korcek including physical therapy. Petitioner reported on February 10, 2010, that the right upper extremity pain had gone away but that he has difficulty with fine motor skills. Petitioner reported to Dr. Korcek on February 17, 2010 that he wants to go back to work and feels that if he is not ready it is not because of his right upper extremity but because of his cardiovascular condition due to his heart attack. Petitioner began work conditioning. Petitioner was released to return to work without restrictions on March 31, 2010. On April 28, 2010, Dr. Korcek notes Petitioner has been working since April 1, 2010. He has difficulties with fine motor skills. He cannot make a complete fist. Dr. Korcek allowed Petitioner to continue work without restrictions, but advised him to continue to follow cardiac restrictions. On September 1, 2010, Dr. Korcek released Petitioner at maximum medical improvement. Petitioner noted continued weakness and loss of fine motor skills and inability to make a fist (PX 4).

Petitioner was examined at his attorney's request by Dr. Coe on May 27, 2014 (PX 18, Ex B). Dr. Coe testified by evidence deposition on March 16, 2016 (PX 18). Petitioner reported complaints of occasional complaints in his neck radiating into his right shoulder and arm with cervical stiffness. He complained of burning and tingling in his right hand with occasional numbness in his right first through third digits with forceful gripping using his right hand. Dr. Coe's examination found loss of grip strength in the right hand. He diagnosed right sided carpal tunnel syndrome, cubital tunnel syndrome and lateral epicondylitis treated surgically. He also noted some findings of left upper extremity nerve entrapment. He stated that the right sided residual symptoms were an

anticipated post-operative outcome. He found the upper extremity conditions causally related to the Petitioner's work activities (PX 18).

Petitioner testified that he returned to work for Respondent in his full duty capacity as the maintenance supervisor. Petitioner testified that he has continued pain in his neck and arms. It is better but he still has burning, tingling and numbness. The right is worse than the left. He has lost strength. He has difficulty picking up screws. He cannot tie a fishing line.

Conclusions of Law

The Parties stipulated that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent manifesting on March 17, 2016 and that Petitioner's conditions of ill being in the upper extremities were causally related to the accident. Petitioner has advanced complaints in the right arm and hand, left arm and hand, and neck. Petitioner's date of accident is before September 1, 2011 and therefore the provisions of Section 8.1b of the Act are not applicable to the assessment of partial permanent disability in this matter.

With respect to Petitioner's right hand and arm, Petitioner advance complaints of pain, numbness and tingling. EMG studies showed carpal tunnel syndrome and cubital tunnel syndrome. Petitioner was ultimately referred to Dr. Korcek who diagnosed bilateral carpal tunnel greater than distal ulnar tunnel, right sided symptoms more pronounced. He also diagnosed right lateral epicondylitis. After a course of conservative treatment including injections and physical therapy, Petitioner underwent right carpal tunnel open release, right ulnar nerve decompression, and right lateral epicondylar debridement on November 13, 2009. Petitioner was released to return to work without restrictions on March 31, 2010. On September 1, 2010, Dr. Korcek released Petitioner at maximum medical improvement. Petitioner noted continued weakness and loss of fine motor skills and inability to make a fist. Petitioner returned to his regular job with Respondent, working until his subsequent accident to the low back (addressed in the consolidated claim 10 WC 49141). Petitioner has not sought further treatment since his release by Dr. Korcek on September 1, 2010. He has not advanced complaints in the upper extremities to any subsequent treating doctor despite extensive subsequent treatment for other medical conditions. Dr. Coe's 2014 examination found loss of grip strength in the right hand. Dr. Coe found him at maximum medical improvement. Petitioner testified that he has continued pain, burning, tingling and numbness. The right is worse than the left. He has lost strength. He has difficulty picking up screws. He cannot tie a fishing line.

The Arbitrator finds the following cases instructive as to the extent of permanent partial disability in the right upper extremity: *Angela Young* v. *State of Illinois-Department of Revenue*, 16 IWCC 160; *Michael McKenzie v. Continental Tire North America, Inc.*, 14 IWCC 434; *Bill Sentel* v. *Continental Tire North America, Inc.*, 14 IWCC 350.

With respect to the Petitioner's left hand and arm, Petitioner did not initially advance left sided complaints to Dr. Gander. The March 17, 2006 EMG/NCV impression was bilateral severe median nerve entrapment neuropathies, severe left cubital tunnel. The February 21, 2008 EMG/NCV interpretation was mild bilateral ulnar neuropathies at the wrist and moderately severe bilateral median neuropathies at the wrist. Despite these findings, Petitioner rarely advanced complaints in the left arm. Petitioner saw Dr. Korcek on March 10, 2008 for complaints of right arm pain due to cutting trees for his job in 2004 and 2005 after a windstorm. Dr.

Korcek's records note only physical examinations of the right hand and arm. On June 18, 2008, Dr. Korcek noted improved right sided symptoms. Left sided symptoms are minimal. Petitioner had no treatment whatsoever specifically directed to the left upper extremity. Petitioner advanced no complaints to the left upper extremity to any subsequent treating doctor despite extensive subsequent treatment for other medical conditions.

With respect to the Petitioner's neck, The March 17, 2006 EMG/NCV impression included possible cervical radiculopathy on the right side at C5-6 and C6-7. Dr. Lyddon recommended a cervical MRI to rule out cord or root compression. The MRI performed May 15, 2006 noted multilevel disc disease. Dr. Alexander's impression was symptoms consistent with right sided C5-6 and C6-7 disc protrusions and spondylosis causing radicular symptoms. He recommended conservative care. On September 22, 2006, Petitioner had undergone physical therapy with traction and reported his neck was significantly improved. Petitioner was working full duty. Dr. Alexander noted that Petitioner is doing well. On January 10, 2008, Dr. Roh stated that Petitioner's symptoms do not emanate from the neck or shoulder. He stated the MRI noted congenital stenosis with multilevel disc protrusions, but no evidence of severe compression. Dr. Coe testified that there was no evidence of double crush syndrome at the time he saw Petitioner. He noted some mild residual neck complaints of stiffness and discomfort with occasional radiation.

Based upon the record as a whole, including the medical evidence submitted and the Petitioner's testimony, the Arbitrator finds that the injuries sustained caused disability of 15% loss of use of the right arm, 12.5% loss of use of the right hand, and 2.5% loss of use of the left arm as provided in Section 8(e) of the Act, and caused 2% loss of use of the whole person as provided in Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF Winnebago)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald E. McFadden,
Petitioner,

vs. NO: 10WC 49141

Cloisters of Forest Hills Corp,
Respondent.

18IWCC0138

DECISION AND OPINION ON REVIEW

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $73,900.00. 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: MAR 8 – 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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CJD/rlc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McFADDEN, RONALD E
Employee/Petitioner

Case# **10WC049141**
07WC056624

CLOISTERS OF FOREST HILLS CORP
Employer/Respondent

18IWCC0138

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:

0529 TUITE LAW
GREGORY E TUITE
119 N CHURCH ST SUITE 407
ROCKFORD, IL 61101

1408 HEYL ROYSTER VOELKER & ALLEN
LYNSEY A WELCH
120 W STATE ST 2ND FL
ROCKFORD, IL 61101

18IWCC0138

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ronald E. McFadden
Employee/Petitioner

v.

Cloisters of Forest Hills Corp.
Employer/Respondent

Case # 10 WC 49141

Consolidated cases: 07 WC 56624

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **January 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 **Reimbursement to Respondent**

FINDINGS

On **July 6, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29.599.60**; the average weekly wage was **$896.96.**

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

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

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

Respondent shall be given a credit of **$25,946.20** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$25,946.20.**

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $597.97/week for 43 weeks, commencing July 7, 2010 through May 3, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $538.18/week for 137.5 weeks, because the injuries sustained caused the 27.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall be given a credit of **$25,946.20** for TTD; Respondent shall have credit against Permanent Partial disability awarded for the **$233.49** overpayment of TTD.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 6, 2017
Date

MAR 8 - 2017

Statement of Facts

This matter was heard in conjunction with consolidated case 07 WC 56624 (accident date March 17, 2006). A single record was prepared, but the Arbitrator has issued separate decisions. A petition for fees by a former attorney is pending. The Arbitrator makes no findings with respect to the fee petition.

Petitioner Ronald McFadden testified that he was employed by Respondent Cloisters of Forest Hills as the maintenance supervisor for 11 years. He had previously worked for Beacon Hill apartments and as a self employed plumber. Respondent is a complex of 144 apartments on 14 acres. Petitioner's duties for Respondent included snow removal, renovation and maintenance of the buildings including the boilers and clearing the land. Petitioner admitted a job analysis and video of certain duties as Petitioner's Exhibits 16 and 17.

Petitioner testified that his regular work week was 40 hours per week. He was scheduled 9 hours per day Monday through Thursday and ½ day on Friday. He also testified that he was on 24 hour call. The July 22, 2010 First Report of Injury also confirms Petitioner was on call 7 days per week (PX 20). Petitioner admitted Petitioner's wage records from June 31, 2009 through July 24, 2010 (PX 21).

Petitioner returned from an extended medical leave in April, 2010. Petitioner had treated for his neck and upper extremity complaints beginning in March, 2006 (which injury is the subject matter of the consolidated case 07 WC 56624). He had been scheduled for right wrist and elbow surgery for December 4, 2008, but surgery was cancelled when Petitioner suffered an acute myocardial infraction on November 28, 2008. Petitioner underwent coronary artery bypass grafting and repair of the right subclavial artery. During his recovery, he was also evaluated on January 17, 2009 by Dr. Hillman for vision defects (RX 4). A CT of the head showed an old small stroke (PX 3). Dr. Gray released Petitioner to return to work on March 13, 2009 with a 40 pound weight restriction. Dr. Gray submitted disability evaluations on April 30, 2009, noting Petitioner suffered from fatigue and dyspnea as well as vision loss (PX 3). Petitioner testified he was discharged from work conditioning after increasing the weights to 40 pounds. He was getting back to normal. He testified he attempted work without restriction and returned to his full duty as the maintenance supervisor.

On April 1, 2009, Petitioner returned to Dr. Korcek to reschedule his surgery. He reported that he is working his regular job part time. On August 24, 2009, Petitioner continued work per the cardiologist restrictions. On November 13, 2009, Petitioner underwent right carpal tunnel open release, right ulnar nerve decompression, and right lateral epicondylar debridement (PX 4). Postoperatively, Petitioner reported to Dr. Korcek on February 17, 2010 that he wants to go back to work and feels that if he is not ready it is not because of his right upper extremity but because of his cardiovascular condition due to his heart attack. On April 28, 2010, Dr. Korcek notes Petitioner has been working since April 1, 2010. Dr. Korcek allowed Petitioner to continue work without restrictions, but advised him to continue to follow cardiac restrictions. On September 1, 2010, Dr. Korcek released Petitioner at maximum medical improvement for his upper extremities (PX 4).

Petitioner testified that on July 6, 2010, he was working removing patios, replacing the cement with wooden decks. He used a jackhammer to remove the concrete. He testified he reached for a 2 by 12 floor joist and felt a pop in his back. He testified that his back tightened up after lunch. And he reported the accident to Sue McDonald. The First Report of Injury completed July 22, 2010 describes Petitioner's back injury on July 6, 2010 while lifting wood to paint for patios. It states the employer was notified on July 6, 2010 (PX 20). Petitioner testified he was scheduled to work on July 7, 2010, but he was unable. He testified he took vacation

through July 24, 2010. He spent the time on his back in bed. Petitioner's time cards reflect he took vacation time from July 6, 2010 through July 24, 2010 (PX 21).

Petitioner had prior medical care for his low back. Petitioner testified he suffered an accident in July, 1988. He fell getting out of an elevator that was not level. Petitioner treated with Dr. Jaworowicz for complaints of low back pain without radiation. He was diagnosed with disc herniations at L3-4 and L4-5. He underwent lumbar epidural injections on November 30, 1989, December 28, 1989, and January 18, 1990. Petitioner returned to the emergency room at Swedish American Hospital on January 25, 1992. At that time, he reported loading a washer and feeling a pop in his central back (PX 10). Petitioner testified that he returned to full, unrestricted duty. A February 11, 2005 routine physical exam by Dr. Gander states Petitioner denies any musculoskeletal or neurologic complaints and finds the axial skeleton, extremities and neurological examinations unremarkable.

Dr. Gray notes severe back pain with probable sciatica in his October 28, 2008 examination. Petitioner reported that he hurt his back a few days ago on November 4, 2008. On November 5, 2008, Petitioner reported low back pain started 10 days ago. The pain starts in his lower back and radiates to the right thigh and into the right knee area. Dr. Gray referred him to the pain clinic (PX 3). During the January 10, 2010 examination by Dr. Roh for the cervical spine, Petitioner reported pain in the right buttock and calf and documented these complaints on a pain diagram (PX 6).

After his return to work in April, 2010, Petitioner was seen at Brookside Immediate Care on April 21, 2010, with complaints in the right side of his lumbar spine described as severe 10/10. Petitioner reported the mechanism of injury was unknown. He was advised to use ice/heat and avoid heavy lifting (PX 7). Petitioner continued treatment with Dr. Schermer, his primary care physician, on May 6, 2010. He reported back pain for the past two months. It started when he went back to work. He thinks it that when he was lifting something his back went out. X-rays showed some arthritis (PX 8). Petitioner telephoned on May 13, 2010 advising he was having spasm and can hardly walk. Physical therapy was initiated (PX 8). On May 21, 2010, Dr. Schermer notes that the Petitioner continues with 10/10 back pain, worse after work. Petitioner denied radiation down his legs, numbness or weakness (PX 9). Petitioner testified that he noticed he was out of shape and described his condition as mild discomfort.

Petitioner was prescribed a course of physical therapy two times per week for four to six weeks beginning on May 21, 2010. Petitioner's physical therapy evaluation note from May 21, 2010, reports progressive low back pain for several weeks. Petitioner reports symptoms began while lifting a 75-pound box overhead two days before he returned to work. He sustained a sneeze and caused a burn to the low back. Petitioner stated two days later he began a new job with lifting moderate to heavy loads on a consistent basis. Prior to that job, he had been unemployed for 14 months due to his cardiac episode and surgery to his right upper extremity. Petitioner reported a poor tolerance to work duties, poor tolerance to functional mobility, and increased lower back pain and stiffness at all times (PX 9). On June 10, 2010, he had had three therapy sessions. Petitioner reported that physical therapy was not helping, and his signs and symptoms were increasing. Petitioner was instructed to follow up with his physician if he felt it was necessary. He was discharged due to noncompliance (PX 9).

After July 6, 2010, Petitioner first sought medical attention at St. Anthony Medical Center Emergency Department on July 14, 2010. Jill Drummond Wentzel testified that she was the ER nurse on duty. She had no independent recollection of the treatment and testified from the records (PX 11). Petitioner waited about 2

hours before the doctor saw him. He was about to leave without being seen. The records contain a history of back pain for about a week since lifting wood at work and twisting. The pain does not radiate. The Review of Systems notes back pain without myalgias or arthralgias. Neurological examination was negative. The pain diagram shows pain only in the center of the low back. The Flow Sheet prepared by Ms. Wentzel states pain in the middle of the back down both posterior thighs (PX 11).

Petitioner was referred to Dr. Ryan Enke for further care. He was first seen on July 30, 2010. Petitioner provided a history of injury on July 6, 2010 due to picking up some lumber at work. He complained of pain in the lower back radiating down both legs with numbness and tingling. He denied any previous significant back problems. Dr. Enke suspected lumbar radiculopathy secondary to a herniated disc and ordered an MRI (PX 4). On August 6, 2010, Dr. Enke read the MRI as showing spinal stenosis, a congenitally narrowed canal and disc herniations at L3-4, L4-5 and L5-S1. Petitioner was scheduled for 4 weeks of conservative care with physical therapy and medication. He was placed on a 10 pound lifting restriction with no bending or twisting (PX 4). Petitioner failed to improve and was scheduled for epidural steroid injections. On November 22, 2010, Dr. Enke noted that Petitioner had two injections without relief and recommended a surgical consultation. Petitioner was limited to 20 pound lifting (PX 4).

Petitioner saw Dr. Roh on December 7, 2010. Petitioner provided a consistent history of the July 6, 2010 work injury with pain in the back and right buttock and leg. There is no prior history if back pain reported. After examination and review of the MRI, Dr. Roh's impression was right lower extremity radiculopathy secondary to severe L3-4 spinal stenosis and disc herniation as well as right paracentral L5-S1 herniated nucleus pulposus with compression of the right S1 nerve root. He recommended surgery consisting of a four level L2-S1 laminectomy with discectomy at L3-4 and L5-S1 (PX 5). Dr. Trotter performed a Utilization Review for Respondent and agreed the surgery was necessary and appropriate (PX 16). Petitioner underwent surgery on January 24, 2011 consisting of an L2-S1 open laminectomy, medial facetectomy and foraminotomies with a microdiscectomy on the left at L3-4 and right sided microdiscectomy at L5-S1 (PX 11).

Petitioner was seen for post operative care through May 3, 2011. Petitioner began physical therapy on March 11, 2011. At that time, he noted a two year history of progressive back pain. He also notes his heart attack and deconditioned state. Petitioner participated in therapy through April 18, 2011. A hand written note in the Nurses Record for April 18, 2011 states Petitioner knows he is coming to the end of his therapy and knows he will not be able to return to his regular duties due to his cardiac and vision issues. Work conditioning is not warranted. Reasonable permanent restrictions for the Petitioner's safety would be 40 pound lifting, no ladders or jackhammers, and change of position every 20 minutes (PX 5). On May 3, 2011, Petitioner reported that his radiculopathy is completely resolved. He notes his back will bother him from time to time if he lifts in a flexed forward position. His main limiting factor is chest pain and shortness of breath from his cardiac condition. Physical examination notes full strength and intact sensation. The impression is complete resolution of his lumbar radiculopathy and a disabling cardiac condition. Dr. Roh released Petitioner to return to work from a lumbar standpoint. He notes Petitioner has decided he is not fit to return to work due to his various medical conditions, not the least of which is his heart. His cardiac condition seems the most disabling (PX 5). Petitioner called Dr. Roh's office on June 20, 2011 noting a sudden onset of right buttock pain while walking (PX 6). Dr. Schermer saw Petitioner for recurrent low back pain without radiation on January 19, 2012 (PX 9).

Petitioner testified that he contacted Sue McDonald after his May 3, 2011 release from care. He testified that she did not feel he could do his job and he agreed. His workers' compensation benefits terminated at that time. He applied for and received unemployment compensation. He applied for disability and was approved.

Petitioner testified that he had additional treatment beginning in July, 2012. He testified that he was walking his dog and it stopped suddenly and he hurt his back. Petitioner was seen at St. Anthony on July 14, 2012. He gave a history of tripping over his dog 10 days ago and started having excruciating pain. He stated he was in bed for 10 days and taking narcotics without pain control. His wife called 911 and he was transported by ambulance (PX 11). An MRI performed July 14, 2012 found multilevel degenerative changes with stenosis and a moderate sized left posterior disc herniation at L4-5 (PX 14) Petitioner was hospitalized through July 17, 2012 (PX 11). Petitioner saw Dr. Roh in consultation on July 16, 2012 for his low back and left leg pain. Dr. Roh did not recommend surgery because of the risks involved. He recommended pain management (PX 6). Petitioner saw Dr. Gahl for an epidural injection on September 18, 2012 (PX 13). Petitioner testified that this is the last treatment he has had specifically for his back. Dr. Schermer saw Petitioner on October 30, 2012 and noted minimal relief from the injection (PX 9). He provided correspondence that Petitioner should be limited to light duty (PX 24). Petitioner testified he continues to see Dr. Schermer, his family doctor, for follow up and prescriptions for his back as well as his multiple other conditions. Dr. Schermer's records note low back complaints through late 2014 (PX 9).

Petitioner testified he continues to have little flair ups of pain. He has not had any other accidents. He continues to have numbness with pain down his legs, worse on the left. He does not shovel snow or cut his grass. He does not fish. He continues to take Flexeril as needed, maybe 2 to 3 times per month. He did go to Apple River in 2011, but did not hunt.

Petitioner was examined by Dr. Jeffery Coe at his attorney's request on May 27, 2014. Dr. Coe testified by evidence deposition taken on March 16, 2016 (PX 18). Dr. Coe took a history of the earlier 1998 and 1999 treatment and the initial Brookside treatment in April, 2010. He reviewed medical records including the May, 2010 treatment by Dr. Schermer. He took Petitioner's history of accident on July 6, 2010 and reviewed the treatment following July 6, 2010 and the further treatment beginning in July, 2012. His report states that Petitioner continues in the care of his family physician, Dr. Schermer, and pain management specialists for left radiculopathy symptoms for the later, 2012, non work related incident (PX 18, Ex 2). He reviewed the Brookside records prior to his testimony. Dr. Coe opined that Petitioner's condition of ill being in the low back was causally connected to the accident on July 6, 2010. He opined that Petitioner aggravated the preexisting degenerative changes in his spine and caused the herniation of the L5-S1 disc and L3-4 disc with right radiculopathy which required treatment including the surgery by Dr. Roh in January, 2011. He testified that there is no evidence of radiculopathy before the July 6, 2010 accident, particularly in the April and May, 2010 treatment records. While Petitioner's back may have been bothering him, it was not severe. He testified that he would place Petitioner currently on a 10 pound lifting restriction (PX 18).

Dr. Coe testified he did not review MRI films. He relied on the radiologists and the interpretation of the studies by the treating surgeon. The congenital narrowing and stenosis would pre-date July 6, 2010. 10 out of 10 pain complaints would not be considered mild. Petitioner advised Dr. Coe that he had chosen not to return to work due to his underlying medical conditions including cardiac and vision. Dr. Roh did not place Petitioner on a 10 pound restriction (PX 18).

Dr. Ryon Hennessy prepared a June 6, 2016 record review report at Respondent's request (RX 2) and an addendum on July 8, 2016 (RX 3). He testified by evidence deposition taken on October 26, 2016 (RX 1). Dr. Hennessy reviewed multiple medical records including the initial 1989 back treatment, a 2006 emergency visit, 2008 back treatment, treatment in April and May, 2010, the July 14, 2010 treatment and treatment thereafter

from Dr. Enke and Dr. Roh, as well as the July, 2012 and following treatment. He reviewed actual MRI films from 2010, 2012 and 2014. He also reviewed the unrelated upper extremity treatment records. Dr. Hennessy opined that Petitioner had a congenitally narrow spinal canal, pre-existing degenerative condition of the lumbar spine and pre-existing disc herniation dating from 1989. He opined that Petitioner's symptoms in July, 2010 were a manifestation of the natural progression of his pre-existing degenerative condition. They were not exacerbated, accelerated or aggravated by the alleged injury of July 6, 2010. He opined that the L5-S1 disc herniation predated the July 6, 2010 accident. Dr. Hennessy testified that Petitioner had prior similar right leg complaints in November, 2008. He also referenced the July 14, 2010 note of Dr. Schaffer which indicated no radiating pain, numbness or tingling. Dr. Hennessy testified that Petitioner denied any prior back problems when he saw Dr. Enke on July 30, 2010. Dr. Hennessy opined that the L4-5 disc herniation, left sided radiculopathy and treatment, all of which began in July, 2012 were not related to the accident. He opined that Petitioner's current complaints were not related to the July 6, 2010 accident. He testified that the treatment rendered was reasonable and necessary. He opined that Petitioner did not require any work restrictions as a result of the accident on July 6, 2010 (RX 1-3).

Dr. Hennessy testified that his opinion that the L5-S1 disc herniation predated the accident was in part based upon the 2008 pain diagram prepared by Petitioner for Dr. Roh showing pain down the right leg and the 2008 records of Dr. Schermer complaining of right leg pain. He testified that there were no such complaints indicating radiculopathy in the April and May, 2010 treatment records (RX 1).

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury occurs "in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury.

Petitioner testified that on July 6, 2010, he was working removing patios, replacing the cement with wooden decks. He used a jackhammer to remove the concrete. He testified he reached for a 2 by 12 floor joist and felt a pop in his back. The First Report of Injury completed July 22, 2010 describes Petitioner's back injury on July 6, 2010 while lifting wood to paint for patios. It states the employer was notified on July 6, 2010. Petitioner provided this consistent history of accident at the emergency room on July 14, 2010, to Dr. Enke on July 30, 2010 and to all of his treating and evaluation doctors thereafter. While the Arbitrator notes other inaccuracies in Petitioner's medical histories, in particular the failure to advise his treaters fully of the extent of his prior back condition, the Arbitrator finds the accident description credible based upon the Petitioner's testimony, the accident report and medical histories, and his unrebutted job duties and work assignment.

There is no dispute that the activity described occurred in the course of his employment. The Arbitrator also finds that the activity of lifting heavy lumbar is a risk connected with, or incidental to, the employment. The Arbitrator notes some variation in the exact accident description between lifting the heavy wood and reaching

for the lumber. The Arbitrator finds that either description is still an employment related risk. Here, claimant's injury arose out of an employment-related risk and is compensable. The record shows Petitioner was injured while performing his job duties. *Young v. Ill. Workers' Comp. Comm'n,* 13 N.E.3d 1252; 2014 Ill. App. LEXIS 498; 383 Ill. Dec. 131 (4th Dist., 2014).

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent on July 6, 2010.

In support of the Arbitrator's decision with respect to (E) Notice, the Arbitrator finds as follows:

Petitioner testified that he reported the accident to Sue McDonald and possibly Jerry Wright. Petitioner's Exhibit 20 is a First Report of Injury completed July 22, 2010 describing Petitioner's back injury on July 6, 2010 while lifting wood to paint for patios. It states the employer was notified on July 6, 2010.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he provided Respondent notice of the accident within the time limits stated in the Act.

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

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. The accident need not be the sole or principal cause, as long as it was a causative factor in a claimant's condition of ill-being. If the claimant had health problems prior to a work-related injury, he bears the burden of showing that the preexisting condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment.

Petitioner herein is seeking compensation for the condition of ill being of his low back as a result of the accidental injury on July 6, 2010. Respondent has disputed the causal connection based upon Petitioner's pre existing condition in the low back and also based upon a subsequent intervening injury in July, 2012.

Petitioner has had prior medical care for his low back. Petitioner treated with Dr. Jaworowicz. He was diagnosed with disc herniations at L3-4 and L4-5. He underwent lumbar epidural injections on November 30, 1989, December 28, 1989, and January 18, 1990. Petitioner returned to the emergency room at Swedish American Hospital on January 25, 1992. At that time, he reported loading a washer and feeling a pop in his central back. Dr. Gray notes severe back pain with probable sciatica in his October 28, 2008 examination. Petitioner reported that he hurt his back a few days ago on November 4, 2008. On November 5, 2008, Petitioner reported low back pain started 10 days ago. During the January 10, 2010 examination by Dr. Roh for the cervical spine, Petitioner reported pain in the right buttock and calf and noted this on a pain diagram he prepared. Petitioner was seen at Brookside Immediate Care on April 21, 2010, with complaints in the right side of his lumbar spine described as severe 10/10. Petitioner reported the mechanism of injury was unknown. Petitioner continued treatment with Dr. Schermer on May 6, 2010. He reported back pain for the past two months. It started when he went back to work. He thinks it that when he was lifting something his back went out. X-rays showed some arthritis. Dr. Schermer notes on May 21, 2010 the Petitioner continues with 10/10

back pain, worse after work. Petitioner denied radiation down his legs, numbness or weakness. Petitioner's physical therapy evaluation note from May 21, 2010, reports progressive low back pain for several weeks. On June 10, 2010, Petitioner reported that physical therapy was not helping, and his signs and symptoms were increasing.

Petitioner continued working for Respondent, including performing the tasks of replacing the cement balconies with wood until the accident on July 6, 2010. Thereafter, Petitioner testified he was bedridden until seeking medical attention on July 14, 2010 at St. Anthony Medical Center Emergency Department. The records and testimony of Ms. Wentzel confirm that he waiting over two hours and was seen only after he had indicated that he was going to leave. While the notes of Dr. Schaeffer state Petitioner had no radiating pain, the Flow Sheet prepared by Ms. Wentzel states pain in the middle of the back down both posterior thighs. Thereafter, Dr. Enke notes radiating pain and begins the course of treatment that leads to Dr. Roh's January 24, 2011 surgery consisting of an L2-S1 open laminectomy, medial facetectomy and foraminotomies with a microdiscectomy on the left at L3-4 and right sided microdiscectomy at L5-S1.

Petitioner offered the opinion of Dr. Coe, who opined that Petitioner's condition of ill being in the low back was causally connected to the accident on July 6, 2010. He opined that Petitioner aggravated the preexisting degenerative changes in his spine and caused the herniation of the L5-S1 disc and L3-4 disc with right radiculopathy requiring treatment including the surgery by Dr. Roh in January, 2011. Respondent offered the opinions of Dr. Ryon Hennessy who opined that Petitioner's symptoms in July, 2010 were a manifestation of the natural progression of his pre-existing degenerative condition. They were not exacerbated, accelerated or aggravated by the alleged injury of July 6, 2010. He opined that the L5-S1 disc herniation predated the July 6, 2010 accident.

Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

Both experts agree that Petitioner had a pre existing degenerative condition, dating back to his initial care 1989. The unrebutted facts are that, other than possibly a few days missed, Petitioner worked at a heavy labor job for many years before he began missing time after July 6, 2010. Petitioner's complaints and condition as documented in the 2008 records of Dr. Roh and Dr. Schermer and addressed by Dr. Hennessy are consistent with the pre existing condition with radiculopathy and even disc pathology. But again, Petitioner returned to work at a heavy physical job. Petitioner's additional medical treatment beginning in April, 2010 corresponds with his return to work for Respondent. The Arbitrator recognizes that Petitioner's testimony, medical histories, and subjective complaints are often contradictory or inconsistent as to the exact description and onset of his symptoms and the severity of his complaints. But the entirety of the evidence supports that his ongoing heavy work was causing non radicular symptoms through which he continued to work, until the July 6, 2010 lifting episode. After that event, he was bedridden for several days, sought ongoing and continuous medical care, was recommended and underwent surgery, and was disabled by his treaters through his May 3, 2011 discharge.

The Arbitrator is loath to place too much emphasis on the single note from Dr. Schaeffer D.O. prepared in a busy emergency room, particularly in light of Ms. Wentzel's notation of bilateral leg complaints at the same visit.

Having viewed the expert opinions in the context of the testimony, treating medical evidence and the sequence of events, including Petitioner's job description and work history, the Arbitrator finds the opinion of Dr. Coe, that Petitioner suffered an aggravation of his pre existing lumbar spine condition as a result of the July 6, 2010 more persuasive and supported by the remainder of the evidence. While it is clear Petitioner was suffering from low back symptoms, at least periodically for years, and that he had increased symptoms following his April, 2010 return to work, the strenuousness of his job duties resulting in the accident and the significant increase in his condition of ill being demonstrated by his inability to work, his seeking emergency treatment, Dr. Enke's documented radicular complaints and significant MRI findings, and the subsequent course of care support the finding of an aggravation.

Having found Petitioner's condition following July 6, 2010 causally connected to the accident, the Arbitrator must address if and when Petitioner reached MMI. Following his surgery, Petitioner was released by Dr. Roh on May 3, 2011. Dr. Roh released Petitioner without restrictions from an orthopedic standpoint. The records are clear that Petitioner felt he could not do his job based upon his cardiac condition. This is consistent with the original 40 pound restriction Petitioner received in March, 2009 and his efforts to obtain disability in 2009. Petitioner admitted he did not return to work for Respondent by mutual agreement. The Arbitrator finds that Petitioner reached maximum medical improvement for his work related low back condition on May 3, 2011 and that Petitioner was released to unrestricted work for his work related back condition per the opinions of Dr. Roh and Dr. Hennessy.

Petitioner presented no evidence that he looked for work thereafter. He applied for unemployment compensation and thereafter has been approved for disability for a combination of medical conditions. He sought little in the way of treatment for his back until his subsequent injury tripping over his dog in July, 2012, more than a year after Dr. Roh's release. Dr. Hennessy provided a specific opinion that the Petitioner's condition and treatment thereafter were unrelated to the July 6, 2010 accident. Dr. Coe referred to the July, 2012 incident as a non work related incident. The Arbitrator finds Dr. Hennessy's opinion unrebutted and persuasive that the Petitioner reached maximum medical improvement for his condition as of May 3, 2011 and that any treatment or further condition of ill being subsequent to May 3, 2011 is not causally connected to the accident, In particular, the July, 2012 incident causing a left L4-5 disc herniation and left radiculopathy is an unrelated, intervening incident.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that his pre existing condition of ill being in the lumbar spine was aggravated by the work related accident on July 6, 2010 and resulted in the subsequent need for medical treatment, lost time and disability up through his release by Dr. Roh on May 3, 2011. The Petitioner reached maximum medical improvement as of May 3, 2011. Any further treatment or additional condition of ill being thereafter is not causally connected to the accidental injury on July 6, 2010.

In support of the Arbitrator's decision with respect to (G) Earnings, the Arbitrator finds as follows:

Petitioner testified that his regular work week was 40 hours per week. He was scheduled 9 hours per day Monday through Thursday and ½ day on Friday. He also testified that he was on 24 hour call. The July 22, 2010 First Report of Injury also confirms Petitioner was on call 7 days per week (PX 20). Petitioner admitted Petitioner's wage records from June 31, 2009 through July 24, 2010 (PX 21). The Arbitrator finds that the Average Weekly Wage listed on PX 20 was calculated using only the last paycheck for the week ending July 10, 2010 and does not properly reflect the wage as required by Section 10 of the Act.

PX 21 includes 33 weeks wages during the year next preceding the accident as required by Section 10. The check issued for June 31, 2009 is before the relevant period, the week of the accident and subsequent July 24, 2010 are also excluded. The arbitrator also has eliminated the middle paycheck on page 3 of the exhibit because the date appears to be inaccurate. Petitioner's hourly wage for the applicable period is $21.95 for 10 weeks and $22.63 for 23 weeks of this period. The Arbitrator notes that while Petitioner does work some overtime hours. he often does not work his full regular 40 hours per week. The overtime worked is not regular.

After reviewing the wage statement, the Arbitrator finds that the proper calculation of the average wage pursuant to Section 10 of the Act is to use Petitioner's hourly rate for the scheduled 40 hour work week. This results in an average weekly wage of $896.96 per week [(10 * 40 * 21.95 + 23 * 40 * 22.63) / 33)].

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that his average weekly wage for the year preceding the accident was $896.96 per week.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that medical treatment for Petitioner's condition of ill being in the low back from July 14, 2010 through the May 3, 2011 release by Dr. Roh is causally connected to the accidental injury suffered on July 6, 2010. Treatment thereafter and in particularly the treatment beginning July 12, 2012 is not causally connected to the accidental injuries sustained on July 6, 2010.

Petitioner has submitted unpaid medical bills as PX 22. Respondent submitted a medical payment log as RX 5. The Arbitrator has reviewed the unpaid bills submitted and the medical records admitted to support the treatment rendered. All of the unpaid bills submitted are for treatment after May 3, 2011 and in particular for treatment after July 12, 2012 and are therefore not causally connected to the accidental injuries sustained.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that Respondent is responsible for any further medical bills in this matter.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, Petitioner is entitled to temporary compensation through his released by Dr. Roh on May 3, 2011. Petitioner testified that was off work from July 7, 2010. The period of compensable lost time totals 43 weeks. Based upon the Arbitrator's finding with respect to Earning that Petitioner's average weekly wage is $896.96, Petitioner's TTD rate would be $597.97. The total TTD owing would be $25,712.71.

The Arbitrator notes an inconsistency between the amounts of TTD paid on Arbitrator's Exhibit 2 and the amounts established by evidence in this matter. Although the Request for Hearing form lists $19,308.80 in benefits paid, RX 6 lists 43 weeks paid at $603.40, consistent with Respondent's claim of the average weekly wage. Petitioner's testimony confirms that he received weekly workers' compensation payments through his release by Dr. Roh on May 3, 2010. The Arbitrator, therefore, finds that the correct amount of benefits paid by Respondent is 43 weeks at $603.40 or $25,946.20. This results in an overpayment of $233.49.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he is entitled to temporary total disability from July 7, 2010 through May 3, 2011 a period of 43 weeks at a rate of $597.97 per week. Respondent is entitled to credit of $29,946.20. The overpayment of $233.49 will be applied against the permanent partial disability awarded herein.

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

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the Petitioner sustained accidental injuries to his low back on July 6, 2010. Said injury resulted in an aggravation of his pre existing degenerative disc condition, resulting in the January 24, 2011 surgical procedure consisting of an L2-S1 open laminectomy, medial facetectomy and foraminotomies with a microdiscectomy on the left at L3-4 and right sided microdiscectomy at L5-S1. Petitioner was released on May 3, 2011 by Dr. Roh to unrestricted work for his back condition. He determined that his overall physical condition would not allow him to return to work. He pursued disability.

Petitioner's date of accident is before September 1, 2011 and therefore the provisions of Section 8.1b of the Act are not applicable to the assessment of partial permanent disability in this matter. The Arbitrator notes the multiple level findings on Petitioner's MRI and the four level surgery performed. The Arbitrator also notes the severity of Petitioner's pre existing condition based upon the medical records and also notes the recent complaints and treatment in April and May, 2010.

Petitioner testified he continues to have little flair ups of pain. He has not had any other accidents. He continues to have numbness with pain down his legs, worse on the left. He does not shovel snow or cut his grass. He does not fish. He continues to take Flexeril as needed, maybe 2 to 3 times per month. The Arbitrator recognizes that Petitioner's complaints on the left side are related to the non work related injury suffered in July, 2012. The Arbitrator also notes the multiple contradictions and inconsistencies in Petitioner's description of his symptoms contained in the medical records and his testimony, such as reporting pain complaints of 10 out of 10 in the medical records in May, 2010 but testifying to minimal pain, or testifying he was not restricted for his cardiac condition, but discussing this as his primary limiting factor repeatedly to his doctors. The Arbitrator also notes Petitioner's propensity to provide incomplete, inaccurate and inconsistent history to his

medical providers. The Arbitrator has taken these factors into account in assessing the weight to be given to Petitioner's testimony.

Based upon the record as a whole, the Arbitrator finds that because the injuries sustained, Petitioner has suffered 27.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

In support of the Arbitrator's decision with respect to (O) Reimbursement to Respondent, the Arbitrator finds as follows:

The Arbitrator notes that Respondent has cited no statutory basis or case law that would allow the Arbitrator to award reimbursement to Respondent for benefits paid. Further, based upon the Arbitrator's findings with respect to Accident, Causal Connection, Temporary Compensation and Nature and Extent, Respondent is not entitled to Reimbursement in this matter. To the extent Respondent has overpaid temporary benefits, the Arbitrator has noted that such overpayment may be used as a credit against the permanent partial disability awarded.

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

STEPHEN QUICK,

Petitioner,

vs. NO: 14 WC 7597

MURRAY CENTER,

18IWCC0139

Respondent,

DECISION AND OPINION ON REVIEW

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

The Arbitrator ordered that "Respondent shall authorize the treatment recommended by Dr. Gray, including, but not limited to, surgery." We find it is not clear what surgery the Arbitrator awarded. Dr. Gray recommended a total knee replacement because he did not believe that another arthroscopy would provide Petitioner with any long-term benefit. However, Petitioner testified that he only wants another arthroscopy at this time (T.29-30) based on the opinion of Dr. Cox. Dr. Gray testified that this would be a reasonable option if Petitioner did not want to undergo the total knee replacement. Therefore, we are clarifying the Decision to award the prospective arthroscopic procedure and related medical expenses. The reasonableness and necessity of a total knee replacement will need to be addressed in the future.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $860.79 per week for a period of 20-5/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this

18IWCC0139

award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $344.77 per week for a period of 36-5/7 weeks, that being the period of temporary partial disability as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $32,778.73 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the prospective arthroscopic left knee procedure and related medical expenses, as discussed above, under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that 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.

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

DATED: MAR 8 - 2018

Charles J. DeVriendt

SE/

O: 1/30/18
49

Joshua D. Luskin

L. Elizabeth Coppoletti

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

QUICK, STEPHEN
Employee/Petitioner

Case# **14WC007597**

MURRAY CENTER
Employer/Respondent

18IWCC0139

On 10/4/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3067 KIRKPATRICK LAW OFFICES PC
ERIC KIRKPATRICK
#3 EXECUTIVE WOODS CT #100
BELLEVILLE, IL 62226

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

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

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

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

OCT 4 - 2016

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

18IWCC0139

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)

Stephen Quick
Employee/Petitioner

v.

Murray Center
Employer/Respondent

Case # 14 WC 7597

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 **Mt. Vernon**, on **July 14, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **October 27, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$67,141.82**; the average weekly wage was **$1,291.19**.

On the date of accident, Petitioner was **53** 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 for **all amounts paid for temporary total disability for the timeframe of October 28, 2013 through June 7, 2015** as stipulated by the parties at the time of arbitration.

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

Respondent shall authorize the treatment recommended by Dr. Gray, including, but not limited to, surgery.

Respondent shall pay the reasonable and necessary medical services in the amount of **$32,778.73** (as included in Petitioner's Exhibit 9) as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to the provider. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit for all benefits paid under its group health plan under Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$860.79**/week for **20 5/7** weeks, **for the timeframe of February 20, 2016 through July 14, 2016,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of **$344.77**/week for **36 5/7** weeks, **for the timeframe of June 8, 2015 through February 19, 2016**, as provided in Section 8(a) of the Act.

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

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

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

Melinda M. Pope-Gillman

Signature of Arbitrator

9/28/16

Date

ICArbDec19(b)

OCT 4 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Stephen Quick
Employee/Petitioner

Case # 14 WC 7597

v.

Consolidated cases: N/A

Murray Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he has worked for Respondent since August of 2010 and that his title is that of a Mental Health Technician II. He testified that he works with disabled adults and helps to take care of their needs, and that sometimes he deals with aggression.

Petitioner testified that he worked overtime, and that some of the overtime was "mandatory" while some was "voluntary." He testified that as to the voluntary overtime he either volunteered or it was mandated, and that he chose to volunteer for certain shifts in order that he could manage his schedule as he had issues with his sleeping patterns. He testified that if the overtime was mandatory, his shifts could switch and he could not control when he worked. He testified that most of the overtime consisted of double shifts.

Petitioner testified that he was involved in an accident on October 27, 2013 when he was on the unit. He testified that an individual came up behind him with a wheelchair, grabbed his knee and "snapped" it. Petitioner testified that his left knee was injured, and that his leg was pulled straight up in the air and that he almost sat in the individual's lap.

Petitioner testified that he had a prior surgery in either 2008 or 2009 on his left knee, and that he was released for that surgery and had no ongoing issues. He denied having any problems immediately before this accident with his left knee. He testified that he came under the care of Dr. Gray at Bonutti Clinic, and that he tried conservative care for a while and also took him off work for a while. He testified that surgery was performed on February 10, 2015, that he was kept off work and was released to work light duty on or about June 8, 2015 when he went back to light duty work. He testified that his light duty restrictions were accommodated, and that he worked light duty until February 19, 2016.

Petitioner testified that Dr. Gray never released him from light duty work and that he still not yet been released to full duty. He testified that when he worked light duty, he was not allowed to work overtime. He denied receiving any partial payments to make up for the difference between his regular wages and overtime. He testified that Respondent quit accommodating his restrictions on February 19, 2016 because his 6 months was exhausted under one of Respondent's regulations/policies.

Petitioner testified that he had some relief after the surgery was performed. He testified that his pain level is typically a 4 in general, but that his knee has become unstable and gives out at certain times. He testified that his left knee will pop and move to the side. He testified that the frequency of the popping

varies, and that sometimes it would happen once or twice monthly while at other times it would happen 3-4 times per week. He testified that he was currently taking medications prescribed by Dr. Gray, and that he had also gone to the emergency room for his knee as well. He testified that he used to be a much larger man, and that he has lost 134 pounds through dietary changes.

Petitioner testified that he does the home exercise program suggested by his therapist. He testified that he was seen by Dr. Stiehl a couple of times, after which he went to the emergency room. He testified that he desired to have a knee arthroscopy with Dr. Gray.

On cross examination, Petitioner testified that since December of 2015, he has lost 134 pounds and that his weight loss had been primarily based upon dietary changes. He testified that in conjunction with the diet change, he was still doing exercises including stretching. He denied walking on a regular basis for exercise. He testified that one of the medications affected the taste of food. He denied that his left knee has improved since he lost the weight.

On cross examination, Petitioner testified that he volunteered for overtime because the overtime would have been mandated anyway. He testified that if the overtime was not mandatory, he still would have sometimes volunteered for overtime.

On cross examination, Petitioner testified that he saw Dr. Stiehl on at least two occasions. He testified that he was in either 2 or 3 car accidents since the date of accident in this case. He denied taking any other pain medications other than Hydrocodone.

The medical records of SSM Health St. Mary's Hospital for a date of service of October 27, 2013 were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen on that date in the Emergency Department, at which time it was noted that he reported that he was grabbed by a resident at Murray Center earlier that day behind the left knee, and that the injury mechanism was by an assault. It was noted that there had been no prior injuries to the area. X-rays performed on that date were interpreted as revealing no apparent fracture or dislocation; no apparent knee joint effusion; minor degenerative change with slight narrowing of medial joint compartment of the knee. The Clinical Impression was that of injury of the left knee and contusion of the knee. (PX1).

The transcript of the deposition of Dr. Timothy Gray was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Dr. Gray testified that he is board-certified and previously performed surgery on Petitioner's left knee in 2008 after which he did well, recovered and went back to work with no restrictions. (PX2).

Dr. Gray testified that he saw Petitioner on October 29, 2013, at which time Petitioner stated that he had a blunt trauma to his left knee sustained when in contact with a combative patient. He testified that Petitioner was treated conservatively, and that he ultimately underwent surgery on February 10, 2015 for a torn meniscus as well as chondromalacia. He testified that he believed that the surgery was related to the blunt trauma Petitioner suffered to the knee in 2013. He testified that for a short period of time Petitioner improved, but did not do as well as his 2008 surgery. He testified that Petitioner continued to have pain in the knee, swelling and irritation of the knee, that he did not trust the knee, and that he did not feel like he could walk long distances. He testified that he thought that Petitioner's knee was "wearing out" and that ultimately he was going to require a left knee replacement. He testified that another arthroscopy was an option, but he did not think it was going to have long-term benefit. (PX2).

Dr. Gray testified that he believed that the knee replacement was a reasonable and necessary option of treatment for Petitioner, and that the need for the knee replacement was related to the accident of October 27, 2013. He testified that the determination for whether a knee replacement was necessary was largely dependent upon symptoms just as much as the findings in the knee. He testified that without

a knee replacement, he thought that the likelihood of getting Petitioner back to full duty activity was very low. He testified that with a knee replacement, he would expect 8-12 weeks before Petitioner would be able to get back to activities. He testified that even with a knee replacement, he was not sure Petitioner would get back to full activity as there were concerns with kneeling, squatting, stairs, interacting with prisoners, animals and combative patients. (PX2).

On cross examination, Dr. Gray agreed that Petitioner has lost weight. He agreed that Petitioner was morbidly obese, and that he was in the morbidly obese category when he first presented in 2013. He testified that Petitioner's weight and BMI would play into his formation of chondromalacia. (PX2).

On cross examination, Dr. Gray testified that there was nothing mentioned in the 2013 MRI regarding a meniscal tear, but that it was confirmed during the arthroscopy. When asked if Petitioner were to lose a significant amount of weight and whether it would still be his opinion that he would need a total knee replacement, Dr. Gray responded that he probably would but did not know for sure. (PX2).

The Operative Report of February 10, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner underwent left knee arthroscopy, partial medial meniscectomy and chondroplasty on February 10, 2015 for a pre-operative diagnosis of left knee medial meniscus tear and post-operative diagnosis of left knee medial meniscus tear, chondromalacia. (PX3).

The medical records of Dr. Gray/Bonutti Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on October 29, 2013 for left knee pain and pain behind the kneecap. It was noted that Petitioner had a blunt trauma to the knee by a combative patient, and that he had had locking, catching, popping and giving way ever since. It was noted that there were no issues with the knee prior to the accident, but that he had a left knee arthroscopy in 2008 and was doing very well. The impression was that of knee complaint, possible lateral meniscus tear. Petitioner was recommended to undergo an MRI and was taken off work. (PX4).

Included within the records was the interpretive report for an MRI of the left knee performed on November 4, 2013, which was interpreted as revealing degenerative thinning of the articular cartilage; subchondral cysts in the intertrochlear groove; Baker's cyst in the popliteal fossa. (PX4).

The records of Dr. Gray reflect that Petitioner was seen on November 8, 2013, at which time it was noted that his symptoms were not changing and that the medication had helped minimally. It was noted that the MRI did not show a meniscus tear, fracture or dislocation, but did show degeneration and inflammation. Petitioner was instructed to remain off work and to continue medications for pain and inflammation. At the time of the November 21, 2013 visit, it was noted that the steroid had helped and that after Petitioner was off the steroid and had an episode where the knee locked up. It was noted that Petitioner had pain on the inner and outer aspects of the knee and that he was having difficulty getting around at times. It was noted that the MRI did not show intraarticular pathology, but that with locking there was a concern about a possible cartilage tear. Petitioner was instructed to remain off work, and to return in 2 weeks. (PX4).

The records of Dr. Gray reflect that Petitioner was seen on December 5, 2013, at which time it was noted that he was doing better but still did not fully trust the knee. It was noted that overall, Petitioner was improving and that he was off work already for "other injuries." Petitioner was recommended to undergo physical therapy and to remain off work. At the time of the December 26, 2013 visit, it was noted that Petitioner had not had therapy but was planning to start on Monday and that he had had no change in treatment since his last visit. It was noted that Petitioner was still having the same complaints. Petitioner was instructed to remain off work and to begin physical therapy. At the time of the January 28, 2014 visit, it was noted that the IME had suggested that Petitioner had a medial meniscus tear and was recommended to undergo surgery. It was noted that Petitioner wanted to avoid surgery if

possible, but that he may require arthroscopy and meniscectomy. It was noted that Petitioner stated that before his IME he probably could have gone back to work, but now he was hurting and was swollen and sore. Petitioner was instructed to remain off work and to return in 2 weeks. (PX4).

The records of Dr. Gray reflect that Petitioner was seen on February 14, 2014, at which time it was noted that his pain and irritation were not getting better and that he wanted to proceed with surgery. Petitioner was recommended to undergo knee arthroscopy, meniscectomy. Petitioner was instructed to remain off work and to schedule surgery at his convenience. At the time of the April 24, 2014 visit, it was noted that Petitioner was still having pain and irritation and that approval had not yet been provided. It was noted that Petitioner was having a hard time getting around, and that his knee still caught, popped and grinded. Petitioner was instructed to remain off work and surgery was recommended. At the time of the August 14, 2014 visit, it was noted that Petitioner was waiting approval for surgery and that Petitioner wished to proceed. Petitioner was instructed to remain off work. A note dated December 2, 2014 noted that surgical authorization had been provided. A note dated December 5, 2014 noted that 4 messages had been left to schedule Petitioner's surgery, and that his wife stated that he was having hip pain and wanted to discuss his hip issues before scheduling surgery. (PX4).

The records of Dr. Gray reflect that Petitioner was issued a work slip dated February 12, 2015 taking him off work after his surgery of February 10, 2015. At the time of the March 5, 2015 visit, it was noted that Petitioner was doing much better but that he still did not fully trust it. Sutures were removed and Petitioner was instructed to remain off work. At the time of the April 2, 2015 visit, Petitioner was noted to be having some pain and that his knee swells, grinds, catches and pops. Petitioner was recommended to begin physical therapy and continue medications for pain and inflammation. Petitioner was also instructed to remain off work. At the time of the April 30, 2015 visit, Petitioner was noted to be still having some pain and irritation, that the medications had helped some and that he thought therapy was helping. Petitioner was instructed to remain off work and to continue therapy. It was noted that Dr. Gray thought it was unlikely that Petitioner would get back to a standing position for gainful employment, and that he may require a knee replacement in the future. It was noted that Petitioner was not improving as Dr. Gray would like, and that he still had residual difficulties. (PX4).

The records of Dr. Gray reflect that Petitioner was issued a work slip on May 29, 2015 allowing him to return to work on June 2, 2015 with restrictions of sedentary work. At the time of the June 4, 2015 visit, it was noted that Petitioner was still having pain and irritation, and that he still had popping and did not fully trust the knee. It was noted that Petitioner had completed a course of physical therapy but was not improving as Dr. Gray would want. It was noted that Petitioner could return to sedentary duty, and that an IME or second opinion was recommended. At the time of the August 10, 2015 visit, it was noted that Petitioner was still having some pain, irritation, catching, popping and grinding, and that he had had an IME. It was noted that Petitioner had enough pain after the IME that he had to go to the emergency room. It was noted that Petitioner's right knee was giving him some difficulty as well, and was probably overuse phenomenon on the right knee because he walked "funny" due to the left knee. Petitioner was issued a work slip allowing him to work sedentary/light duty as of September 16, 2015. (PX4).

The records of Dr. Gray reflect that Petitioner was seen on September 16, 2015, at which time it was noted that he was getting back to full duty and was still having pain. It was noted that Petitioner's spine specialist needed him to lose weight to consider injections and surgical intervention of his spine, and that Petitioner wanted to try exercises and was concerned about his knee popping. A hinged knee brace was recommended and he was instructed to continue medication for pain and inflammation. Petitioner was allowed to continue working light duty and was recommended to obtain a second opinion by a knee specialist in the St. Louis region. At the time of the October 28, 2015 visit, it was noted that Petitioner's left knee still hurts, pops and grinds, and that Dr. Gray thought he was going to require a total knee replacement in the future. A second opinion was again recommended. Petitioner was allowed to return to light duty/sedentary work. (PX4)

The records of Dr. Gray reflect that Petitioner was seen on December 23, 2015, at which time he was seen for bilateral knee issues. It was noted that Petitioner's left knee was still giving him problems, and that he had degeneration as well as tenderness. Petitioner was allowed to return to light duty/sedentary work and he was instructed to continue his medication for pain. At the time of the January 28, 2016 visit, it was noted that Petitioner was being seen for bilateral knee complaints and that his left knee was still having pain and irritation. It was noted that Dr. Cox had ordered repeat x-rays and an MRI. It was noted that Dr. Gray thought an arthroscopy was a "waste of time" and that Petitioner had failed conservative measures. It was also noted that Petitioner awaited his third opinion. Petitioner was allowed to return to light duty/sedentary work. At the time of the February 25, 2016 visit, it was noted that Petitioner was still having pain and irritation and that he had a third opinion. It was noted that Dr. Gray thought Petitioner was going to need a knee replacement, but that other conservative options could be tried. Petitioner was instructed to continue restricted duty and to undergo physical therapy, and that he could also undergo injections. (PX4).

The records of Dr. Gray reflect that Petitioner was seen on March 10, 2016, at which time it was noted that the IME recommended a knee injection and that if it helped, consider knee arthroscopy and meniscectomy. It was noted that Petitioner still had not started physical therapy. An injection was performed. At the time of the March 31, 2016 visit, it was noted that the injection at the last visit made Petitioner's knee worse and that he was having pain and irritation. It was noted that Petitioner had to go to the emergency room and that he had a difficult time getting around. It was noted that Petitioner was off work at that time and was not getting better. It was also noted that Petitioner wanted to try to avoid a knee replacement and that conservative measures were not helping, and that he wanted to go with knee arthroscopy. Petitioner was instructed to remain off work. (PX4).

The records of Dr. Gray reflect that Petitioner was seen on May 18, 2016, at which time it was noted that his knee was still giving him difficulty and that he had pain and irritation with popping, catching and grinding. It was noted that Petitioner stated that he had been losing weight. It was noted that Dr. Gray still thought Petitioner needed a total knee replacement. (PX4).

The medical records of Dr. Elizabeth Cox were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on February 25, 2014 regarding headaches since a work injury where a client "tried to take his head off." It was noted that Petitioner had pain from his head down to his left foot. Petitioner was seen on January 29, 2015 for pre-operative clearance for a left knee meniscectomy. It was noted that Petitioner had constant pain in the left knee but it intensified depending on the way he stepped, and that he had numbness of the left outer thigh. It was noted that final clearance was based on pending labs. (PX5).

The records of Dr. Cox reflect that Petitioner was seen on January 6, 2016, at which time it was noted that he wanted to see Dr. Mall for further care for his knee injury. It was noted that Petitioner had undergone surgery on the left knee in February of 2015 but that it continued to pop and buckle with standing and movement and that it felt like someone had jabbed a knife into the back of the knee. It was noted that Petitioner had numbness in the left leg all of the time, and that some degree of numbness was present before the work injury but that it was worse since the work injuries (July 2013 and October 2013). It was also noted that Petitioner had left-sided hip pain since his injuries in July of 2013 and October 2013, and that his hip started popping after the October 2013 injury. Petitioner was also seen for left-sided shoulder pain since the July 2013 work injury as well. Petitioner was given a referral to Dr. Mall for evaluation of left knee pain/instability, and x-rays and an MRI of the left knee were ordered as well. (PX5).

The records of Dr. Cox reflect that Petitioner was seen on May 12, 2016 for issues with hypothyroidism. It was noted that, among other things, Petitioner's left knee was still popping. At the time of the April 4, 2016 visit, it was noted that Petitioner was being seen for follow-up of seizures, and

that he was having trouble doing math. It was noted that Petitioner was off work per Dr. Gray due to his left knee pain, and that he had an injection in March which caused pressure in the knee and it started popping. It was noted that Petitioner was looking at having a second knee scope. At the time of the March 1, 2016 visit, Petitioner requested a neurology referral and it was noted that he was diagnosed with seizures. (PX5).

The medical records of SSM Health St. Mary's Hospital for a date of service of August 6, 2015 were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner was seen on that date for leg pain after manipulation by a physician. It was noted that Dr. Stiehl flexed Petitioner's knee, and that Petitioner had pain from below the left knee to the hip which he described as burning with occasional numbness. Petitioner was diagnosed with tendinitis of the left knee and thigh. X-rays of the left knee performed on that date were interpreted as revealing no apparent fracture, dislocation or knee joint effusion; minimal degenerative change at knee similar to August 24, 2014 in appearance. Petitioner was placed in a knee immobilizer. (PX6).

The medical records of St. Anthony's Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Petitioner was seen on March 25, 2016, at which time he presented with left knee pain that started two weeks after receiving a steroid injection. It was noted that Petitioner was unaware of any new trauma, and that he was recently taken off worker's compensation and was concerned this may be an extension of his previous injury. The primary impression was that of chronic knee pain. Petitioner was instructed to stay off work until cleared by Dr. Gray. (PX7).

The records of Dr. Mall were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Petitioner was seen on February 12, 2016 for left knee complaints. It was noted that Petitioner had undergone surgery in February of 2015, after which he had continued pain in the left knee that had been preventing him from returning back to work in a full-duty manner. It was noted that Petitioner was sent back to work light duty in June of 2015. The assessment was that of left knee pain, status post left knee arthroscopy and partial meniscectomy. The records reflect that Dr. Mall recommended a left knee intraarticular injection of cortisone. It was noted that if he had substantial benefit then he would potentially be a candidate for a repeat arthroscopy, and that if no benefit was received then it was likely a rehabilitation issue and continued physical therapy should be performed. It was noted that Petitioner did not have substantial arthritis and that Dr. Mall would not recommend total knee arthroplasty. (PX8).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The List of Overtime Hours was entered into evidence at the time of arbitration as Petitioner's Exhibit 10.

The Appearance of Representative was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

The IME Report of Dr. James Stiehl dated January 17, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The report indicated that Petitioner was seen on January 15, 2014 for injuries sustained on July 23, 2013 and October 27, 2013. It was noted that an individual jumped up in the air and injured Petitioner's left knee. It was noted that the injury to the left knee occurred on October 27, 2013, and that a resident somehow grabbed his left knee and it popped. It was noted that Petitioner offered the prior history of left knee arthroscopy back in 2008, and that he was still having some pain in the left knee. It was noted that Petitioner continued to have chronic left knee pain with occasional buckling and popping, and that he had occasional numbness in his left lower extremity. It was noted that Dr. Stiehl opined that Petitioner had evidence of internal derangement of the left knee and a probable tear of the left medial meniscus as a result of the October 27, 2013 injury based on the history provided by Petitioner, and that it was likely and medically probable that the incident caused the meniscus

problem. The report indicated that Dr. Stiehl recommended diagnostic arthroscopy and a probable arthroscopic meniscectomy, and that his condition should be treated with restrictions of stooping, bending and twisting activities which were temporary until the condition resolved. It was noted that Dr. Stiehl opined that Petitioner had not yet reached maximum medical improvement for any injury of October 27, 2013 and that the typical recovery for was 3-6 weeks following surgery. (RX3).

The IME Addendum Report of Dr. James Stiehl dated August 5, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The report indicated that Dr. Stiehl evaluated Petitioner on August 5, 2015. It was noted that Petitioner had been taken to surgery on February 10, 2015 at which time a second partial medial meniscectomy of the medial meniscus was done in addition to a chondroplasty of the articular surfaces. It was noted that the left knee continued to pop, and that he was able to walk unrestricted around Wal-Mart. It was noted that Petitioner had occasional pain in stairs and occasional sharp pains, that occasional swelling was noted but that he denied stiffness. It was also noted that Petitioner denied buckling or giving way, and that he felt there was some low-grade discomfort in his left hip. With respect to objective findings, Dr. Stiehl noted that Petitioner had normal ligaments, neutral alignment without effusion and excellent strength, but low-grade discomfort over the anteromedial aspect of his left knee. Dr. Stiehl's diagnosis was noted to be that of low-grade left knee pain and a resolved condition of a partial tear of the medial meniscus. It was noted that Dr. Stiehl believed that Petitioner did not require additional medical treatment and that he was at maximum medical improvement. It was noted that Dr. Stiehl was of the opinion that Petitioner could return to work without restrictions and that he had reached maximum medical improvement as of the date of the examination (*i.e.*, August 5, 2015). Dr. Stiehl provided an AMA impairment rating of 2% of the lower extremity or 1% whole person impairment. (RX4).

The IME Addendum Report of Dr. James Stiehl dated July 7, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The report reflects that Dr. Stiehl learned that Petitioner had had a left knee surgery back in 2008, where a medial meniscectomy had previously been done. The report reflects that Dr. Stiehl learned that Petitioner had had an MRI of the left knee on November 4, 2013. Dr. Stiehl indicated that the fact that Petitioner had had prior arthroscopic surgery to his left knee consistent of removal of the medial meniscus changed his opinion, and he noted that it was unlikely that an arthroscopic surgery was going to be helpful for Petitioner. Dr. Stiehl opined that Petitioner had low-grade degenerative changes that could respond to conservative treatment such as injections or physical therapy. (RX5).

The IME Addendum Report of Dr. James Stiehl dated August 12, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The report reflects that Dr. Stiehl noted that his assessment of the MRI of November 4, 2013 was that the meniscus had not been adequately removed at that time, which changed his opinion in the report dated July 7, 2014. The report indicated that Dr. Stiehl opined that there was still meniscus remaining that was not adequately removed from the prior arthroscopic procedure and therefore could potentially be causing meniscal entrapment and chronic pain that Petitioner experienced. (RX6).

The IME Addendum Report of Dr. James Stiehl dated October 19, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The Arbitrator notes that the opinions contained in the report referred to the July 23, 2013 claim unrelated to the matter at hand. (RX7).

The medical records of St. Mary's Good Samaritan (incorrectly referred to as The Orthopedic Center of St. Louis on Respondent's Exhibit List/AX4) were entered into evidence at the time of arbitration as Respondent's Exhibit 8. The records were effectively duplicative of those as contained in Petitioner's Exhibits 1 and 6. (RX8; PX1; PX6).

The medical records of Bonutti Clinic were entered into evidence at the time of arbitration as Respondent's Exhibit 9. In addition to containing the medical records as contained in Petitioner's Exhibit 4, the records reflect that Petitioner underwent a left knee arthroscopy on August 10, 2009 after painful symptoms of the left knee following an altercation in January of 2009. The last post-operative follow-up note was dated December 11, 2009, at which time it was noted that the left knee was a little better, that it popped less, that Petitioner was doing regular duty, that Petitioner was doing no physical therapy, that he had no new complaints and that he had no new injury. The diagnosis was that of status post left knee arthroscopy, doing well; low back pain. (RX9; PX4).

The Attendance Records from Payroll were entered into evidence at the time of arbitration as Respondent's Exhibit 10. The Attendance Records Spreadsheet was entered into evidence at the time of arbitration as Respondent's Exhibit 11.

CONCLUSIONS OF LAW

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to his accident of October 27, 2013.

Having considered and reviewed the entirety of the medical evidence in the case, the Arbitrator places greater reliance upon the opinions of Dr. Gray in this case given his regular, ongoing care and treatment of Petitioner coupled with the continued indications in the medical records of ongoing difficulties with the left knee at the various post-operative visits with Dr. Gray. The Arbitrator notes that the medical records in this case demonstrate a lack of progress towards resolution of Petitioner's left knee symptomatology after the arthroscopy was performed on February 10, 2015, and the Arbitrator further notes that Petitioner testified that he still has difficulties with his left knee despite a significant weight loss.

As a result of the foregoing, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to his accident of October 27, 2013.

With respect to disputed issue (G) pertaining to earnings, the Arbitrator notes that Petitioner claims the average weekly wage to be $1,219.19 including overtime (at a straight-time rate), while Respondent claims the average weekly wage is $774.03 after excluding overtime.

The Arbitrator finds that that the evidence in the case demonstrated that Petitioner worked a significant number of hours. Petitioner testified that with regard to the "voluntary" aspect of the hours listed on Petitioner's Exhibit 10, the overtime was going to be mandatory and that the "voluntary" aspect of it was that he had the opportunity to choose the overtime shift or hours to work as opposed to Respondent telling him which shifts or hours he would work. Petitioner testified that this allowed him to maintain somewhat of a regular sleep schedule, and he further suggested that Respondent was short staffed. The Arbitrator finds that the amount and similarity of Petitioner's overtime as evidenced in Petitioner's Exhibit 10 is such that it was part of his regular hours and was continuously worked.

Based on the foregoing, the Arbitrator finds that Petitioner's overtime hours should be included in his average weekly wage calculation (at a straight-time rate) and that the average weekly wage is that of $1,219.19

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary, and causally related to his work accident of October 27, 2013. As a result

thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding as to the issue of causation, the Arbitrator finds that Respondent shall authorize the treatment recommended by Dr. Gray, including, but not limited to, surgery.

With respect to disputed issue (L) pertaining to temporary total disability benefits and temporary partial disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits from February 20, 2016 through July 14, 2016, and that Petitioner also seeks temporary partial disability benefits from June 8, 2015 through February 19, 2016. (AX1).

The Arbitrator notes that the parties stipulated at the time of arbitration that Petitioner was temporarily totally disabled for the timeframe of October 28, 2013 through June 7, 2015, and that Respondent paid temporary total disability benefits for this period of time. (AX1). The Arbitrator notes that Petitioner testified that he returned to work on a light duty basis on June 8, 2015, and that his light duty restrictions as issued by Dr. Gray were accommodated by Respondent until February 19, 2016. The medical records of Dr. Gray reflect that Petitioner's light duty restrictions continued subsequent to February 19, 2016. (PX2; PX4). As a result, the Arbitrator finds that Petitioner was temporarily and totally disabled for the timeframe of February 20, 2016 through July 14, 2016 (*i.e.*, the date of arbitration), a total of 20 5/7 weeks.

The Arbitrator notes that Petitioner further claims entitlement to temporary partial disability for the timeframe of June 8, 2015 through February 19, 2016, and that he claims temporary partial disability benefits given the difference between his regular pay and the average weekly wage (including overtime at a straight rate). The Act states that "[w]hen the employee is working light duty on a part-time basis or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job or jobs, then the employee shall be entitled to temporary partial disability benefits." 820 ILCS 305/8(a). Having previously determined that Petitioner's average weekly wage prior to the accident was $1,291.19, the Arbitrator finds that Petitioner's temporary partial disability rate equals $344.77, which is 2/3 of the difference between the regular base pay of $744.03 and the average weekly wage of $1,291.19. As the evidence in this case demonstrated that Petitioner returned to light duty on June 8, 2015 and that he continued to work on a restricted basis until February 19, 2016 which was the unrebutted point at which Respondent's accommodation of such light duty restrictions ceased, the Arbitrator finds that Respondent shall pay the sum of $344.77/week for a period of 36 5/7 weeks, covering the timeframe of June 8, 2015 through February 19, 2016, as provided in § 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.

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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kameron Williams,

Petitioner,

vs. NO: 16 WC 6263

Hyper Microsystems,

18IWCC0140

Respondent.

DECISION AND OPINION ON REVIEW

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

1. The Commission finds that Petitioner's current condition of ill-being relating solely to his left-hand ganglion cyst and his subsequent complaints of finger numbness and stiffness is causally related to the work accident.

   At the hearing, Petitioner complained of continued left hand pain, pain and stiffness of the left small and ring fingers, neck pain, and left arm pain and stiffness. Although the Arbitrator did not directly address the causal relation of Petitioner's neck and left arm complaints, the Arbitrator awarded medical expenses relating to those complaints. The Arbitrator also awarded medical expenses and prospective medical relating to Petitioner's cubital tunnel diagnosis. Thus, the Commission infers the Arbitrator determined Petitioner's neck, left shoulder, and cubital tunnel complaints are causally related to the work accident. The Commission finds this causation determination to be in error. Petitioner testified that he did not experience shoulder or neck pain until after

he resumed working full duty in January 2016. Petitioner testified that he did not experience left elbow pain immediately following the work accident. Petitioner testified that he experienced only pain in his left hand immediately following the work accident. Dr. Papierski, Petitioner's current treating physician, opined that Petitioner's cubital tunnel syndrome is most likely related to his combination of risk factors including force and repetition. No doctor has opined that Petitioner's cubital tunnel diagnosis is causally related to the work accident.

Petitioner's original treating surgeon, Dr. Ellis, opined that the work accident most likely irritated Petitioner's left-hand ganglion cyst. Dr. Papierski's notes also indicate the ganglion cyst is related to the work accident. Dr. Papierski opined that Petitioner's ongoing complaints regarding finger stiffness and numbness are likely postoperative scarring or fibrosis and recommended tenolysis or tenosynovectomy of the left ring finger. Respondent's IME doctor, Dr. Fetter, opined that Petitioner's ganglion cyst is unrelated to the work accident; however, he agreed that Petitioner's complaint of finger stiffness is likely a complication from the ganglion cyst extraction. Dr. Fetter opined the recommended tenolysis or tenosynovectomy of the left ring finger is reasonable.

For these reasons, the Commission finds Petitioner's complaints regarding his left shoulder, neck, and left elbow are not causally related to the work accident. Furthermore, the Commission finds that only Petitioner's left ganglion cyst and his subsequent complaints of finger stiffness and numbness are causally related to the work accident.

2. The Commission finds only medical services relating to Petitioner's left-hand ganglion cyst and subsequent complaints of finger stiffness and numbness are causally related to the work accident.

   The Arbitrator found all the medical treatment relating to Petitioner's left hand injury as well as his left arm and neck complaints reasonable and necessary. Thus, the Arbitrator ordered Respondent to pay all expenses relating to medical treatment for Petitioner's left hand injury and subsequent left arm and neck complaints. Petitioner submitted outstanding medical bills totaling $7,547.00. These expenses include treatment and services relating to complaints or conditions the Commission has determined are not causally related to the work accident—namely, Petitioner's left shoulder, neck, and cubital tunnel syndrome. The Commission modifies the Arbitrator's award of all submitted medical expenses and finds Respondent liable only for medical services causally related to the work accident. Thus, the Commission finds only medical bills relating to Petitioner's left-hand ganglion cyst and the subsequent complaints of finger stiffness and numbness are reasonable, necessary, and related to the work accident.

3. The Commission finds only prospective medical in the form of the recommended tenolysis or tenosynovectomy of the left ring finger is reasonable and necessary.

The Arbitrator's award of prospective medical includes the recommended tenolysis or tenosynovectomy of the left ring finger as well as a left ulnar nerve transposition. As explained above, Petitioner's current condition of ill-being only as it relates to his left-hand ganglion cyst and subsequent complaints of finger numbness and tingling is causally related to the work accident. Petitioner is entitled only to prospective medical that is related to these conditions. Therefore, the Commission finds Petitioner is entitled to the recommended tenolysis or tenosynovectomy of the left ring finger.

4. The Commission finds that Petitioner is entitled to temporary total disability benefits only from December 4, 2015 through December 10, 2015.

   The Arbitrator awarded TTD benefits from December 4, 2015 through December 10, 2015 as well as from February 20, 2016 through November 2, 2016 (the date of hearing). The Commission agrees that Petitioner is entitled to TTD from December 4, 2015 through December 10, 2015. However, the Commission finds that Petitioner did not meet his burden of proving entitlement to any additional TTD benefits. On February 19, 2016, Respondent terminated Petitioner. Petitioner was working full duty at the time of his termination. On February 20, 2016, Dr. Henriquez prescribed work restrictions limiting Petitioner to right-hand use only. In April 2016, the doctor imposed a five-pound weight restriction with no reaching above the shoulder and no prolonged repetitive arm or hand motions. Dr. Papierski later prescribed a ten-pound weight restriction. However, there is no evidence that the doctors prescribed these restrictions due to Petitioner's complaints regarding his left hand and fingers. Instead, the restrictions and the Arbitrator's reasoning are based on Petitioner's shoulder and arm conditions that are not compensable. Likewise, the Commission notes that Petitioner did not testify that his left-hand complaints prevent him from working in his chosen profession. In fact, Petitioner testified that he continued to work in his regular job without restrictions up to the date of his termination.

   Based on the foregoing, the Commission finds Petitioner failed to meet his burden of proving his work-related injuries made him temporarily and totally disabled from work from February 20, 2016 through November 2, 2016. The Commission finds Petitioner was temporarily and totally disabled in regards to his compensable left hand injury from December 4, 2015 through December 10, 2015, or one week. Respondent shall receive credit for any previously paid TTD benefits.

5. The Commission finds that Petitioner is not entitled to an award of penalties and fees.

   The Arbitrator awarded penalties and fees pursuant to §§16, 19(k), and 19(l) of the Act. After reviewing the record, the Commission finds that Respondent's denial of additional TTD and medical expenses does not meet the level of unreasonable or vexatious action that warrants an award of penalties and fees.

   Respondent paid TTD benefits from December 4, 2015 through December 10, 2015. Respondent then paid additional TTD benefits in February 2016 and March 2016. Respondent terminated TTD after receiving Dr. Fetter's report denying a causal

relation between Petitioner's work accident and his left-hand condition. While the Commission finds the opinions of Drs. Ellis and Papierski regarding the causal relation of Petitioner's left-hand ganglion cyst and complaints of finger numbness and stiffness to be more credible that that of Dr. Fetter, Respondent's reliance upon Dr. Fetter's opinion was not unreasonable. There was a true controversy regarding causation and Petitioner's various claimed injuries. This genuine dispute regarding causation necessarily created controversy regarding Petitioner's entitlement to ongoing TTD benefits and medical expenses. The Commission agrees with Dr. Fetter's opinion that there is no causal link between Petitioner's left shoulder, neck, and left elbow conditions and the work accident. An award of penalties and fees pursuant to §§16, 19(k), and 19(l) of the Act is allowable only when the evidence supports a finding that Respondent's denial of benefits is unreasonable, vexatious, or without good cause. Based on the foregoing, the Commission reverses the Arbitrator's award of penalties and fees.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated February 27, 2017 is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay temporary total disability benefits to Petitioner in the sum of $440.30 per week for 1 week, commencing 12/4/2015 through 12/10/2015, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical services that relate only to treatment regarding Petitioner's left-hand condition including the ganglion cyst and finger complaints, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical services relating to the recommended tenolysis or tenosynovectomy of the left ring finger.

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

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

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

18IWCC0140

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 8 - 2018

o: 1/8/18
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

WILLIAMS, KAMERON T
Employee/Petitioner

Case# **16WC006263**

HYPER MICROSYSTEMS INC
Employer/Respondent

18IWCC0140

On 2/27/2017, 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 0.67% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 301
CHICAGO, IL 60654

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

18IWCC0140

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 19(b)

KAMERON T. WILLIAMS
Employee/Petitioner

v.

HYPER MICROSYSTEMS, INC.
Employer/Respondent

Case # 16 WC 6263

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **JESSICA HEGARTY**, Arbitrator of the Commission, in the city of **WHEATON**, on **NOVEMBER 2, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

☐ TPD ☐ Maintenance ☒ TTD

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

N. ☐ Is Respondent due any credit?

O. ☐ Other **Penalties/Fees**

FINDINGS

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

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

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

In the year preceding the injury, Petitioner earned **$34,348.01**; the average weekly wage was **$660.53**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of for any TTD payments made prior to the hearing.

Respondent shall receive credit for any benefits paid under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services of $7,547.00, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of:

$1648 to Chicago Hand & Ortho
$3554 to Midwest Hand Surgery
$1925 to Progressive Medical Center and,
$420 to Elmhurst Hospital as provided in Sections 8(a) and 8.2 of the Act.

Accordingly, Respondent shall pay reasonable and necessary medical services of **$7,547.00** 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.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $440.30/week for 37 3/7 weeks, commencing 12/4/2015 & 2/20/2016 through 12/10/2015 & 11/2/2016, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 10/19/2015 through 11/2/2016, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit 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.

Penalties

The Arbitrator finds that the Respondent is responsible for 50% of all awarded unpaid temporary total disability benefits, unpaid medical benefits as provided in Section 19(k) of the Act. The Arbitrator finds that the Respondent is responsible for 20% of all awarded unpaid temporary total disability benefits, unpaid medical benefits as provided in Section 16 of the Act. The Arbitrator finds that the Respondent is responsible for $10,000.00 as provided in Section 19(l) of the Act.

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

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

Signature of Arbitrator

2/17/17
Date

ICArbDec19(b)

FEB 27 2017

IN SUPPORT OF ARBITRATOR'S DECISION, THE ARBITRATOR MAKES THE FOLLOWING FINDINGS OF FACT:

On the accident date Petitioner was single with two minor dependent children. He was hired by Respondent, Hyper Microsystems, Inc., in June of 2014 as a warehouse associate. Around January 2015, Petitioner was promoted to sales associate where he sold small and large appliances. He worked Monday through Friday from 8:00 am to 5:00 pm and was paid $10.50 per hour plus commission.

On October 19, 2015, Petitioner was working in the warehouse conducting inventory of large microwaves. Petitioner testified that the inventory process consisted of moving the microwaves manually from one pallet to another. Petitioner testified that the microwaves were fairly large and heavy and he was not wearing gloves or safety equipment at the time. As he was moving the microwaves from one pallet to another, he was carrying a large microwave and holding it at the corners with his both hands. One of the microwave corners was in the palm of his left hand. As he turned he struck a metal rack and the corner of the microwave jammed into his left palm. Petitioner testified that he dropped the microwave because of the impact/pain. He noticed redness in his palm, but did not think it was serious.

Petitioner continued to work, finishing his shift. Over the course of the next two days, the pain in his palm increased and he began to have trouble while working.

Petitioner sought initial treatment at Adventist Glen Oakes Hospital Emergency room where he was examined and later referred to Midwest Hand Surgery.

On October 30, 2015, Petitioner presented to Midwest Hand Surgery where Dr. Ramsey Ellis diagnosed a ganglion cyst in the left palm that required surgery. (Px 2). Dr. Ellis noted the ganglion cyst was irritated by the trauma. (Id.). On December 4, 2015, Dr. Ellis performed surgery under local anesthesia to remove the ganglion cyst. (Id.).

After the surgery Petitioner continued to have pain and swelling in his left palm. The surgery site remained sensitive and was accompanied by peeling skin. (Px 11 – Photos of Petitioner's left palm). Petitioner also began to have problems bending his middle and ring finger.

Petitioner testified that Dr. Ellis kept him off work for one week before instituting light duty restrictions. Respondent accommodated Petitioner's restrictions for about five weeks, before informing Petitioner that he had to perform his regular duties. Petitioner was still on restrictions during this period of time. Petitioner began to develop pain in his left elbow and left shoulder. Petitioner reported his complaints to Dr. Ellis several times after the ganglion cyst removal. Petitioner testified that when he was released to return to work full duty by Dr. Ellis, he decided to obtain a second opinion.

Petitioner returned to work full duty and was there for about one month when he was discharged by Respondent. Petitioner testified that his employer informed him that the reason for his termination was that his department was to be shut down. Petitioner

testified that his department has not been shut down. Petitioner requested authorization from the workers' compensation carrier to obtain a second opinion. During this period of time, Petitioner continued to receive massage therapy for the surgical scar at Midwest Hand Surgery. Petitioner was also receiving physical therapy for his left shoulder at Progressive Medical Center under the care of Dr. Rolando Henriquez. (P x 3).

Petitioner obtained an appointment with Dr. Papierski of Chicago Hand and Orthopedic Surgery on April 8, 2016 after the workers' compensation insurance carrier authorized the appointment. Dr. Papierski examined the Petitioner, noting his inability to extend his middle and ring finger. (P x 1). Dr. Papierski opined that Petitioner sustained post-operative scarring or fibrosis extending into the area of the carpal tunnel, limiting the range of motion on all fingers to some degree. (P x 1). Dr. Papierski recommended Petitioner undergo electro diagnostic testing and continue with therapy for his left shoulder complaints. (P x 1). Petitioner through his attorney requested that Respondent's insurance carrier authorize the electro diagnostic testing.

On August 9, 2016 the electro diagnostic testing revealed left cubital tunnel syndrome and left carpal tunnel syndrome. Dr. Papierski recommended Petitioner continue with occupational therapy.

On September 14, 2016 Dr. Papierski examined the Petitioner noting his surgical recommendation of tenolysis/tenosynovectomy of the left ring finger and left ulnar nerve transposition, sub muscular. (P x 1). Dr. Papierski restricted the Petitioner to right hand work only and limited his left hand to 10lb lifting. Respondent did not authorize the surgery.

Petitioner is currently under restrictions and is unable to work. Petitioner testified that he has only received approximately four weeks of TTD payments that he recalls. Petitioner also testified that his TTD checks were for approximately $240 or $280, under the minimum TTD amount for having two dependent children under 18 years old.

(F): WHETHER PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY

Respondent does not dispute that Petitioner sustained an accident while an employee of the Respondent, but disputes the nature and extent. Petitioner testified that after notify the Respondent of his injury, he sought medical treatment on his own.

The medical records and Petitioner's testimony support a finding that Petitioner's injuries, are causally related to her injury that occurred on October 19, 2015. The Arbitrator notes Dr. Fetter's IME was performed prior to Petitioner's visits with Dr. Papierski and the results of the electrodiagnostic testing. Both Dr. Ellis and Dr. Papierski concluded that Petitioner's condition is related to the trauma that occurred on October 19, 2015. (P x 1, P x 2).

The Arbitrator found Petitioner's testimony credible and supported by the medical records and additional evidence submitted.

(G): PETITIONER'S EARNINGS

Petitioner testified that he worked for the Respondent since June 2014. Petitioner testified that he earned $10.50 per hour plus commission. Petitioner testified that his commissions were paid on a monthly basis. Petitioner testified that he earned a total of $34,348.01 in the year 2015 when presented with the W-2 provide by the Respondent. Petitioner testified as to his earnings in 2015 and submitted a copy of his 2015 W-2. (P x 7). The Arbitrator finds that Petitioner's testimony along with the documentation submitted indicates that he was earning approximately $660.53 per week in the year preceding the accident.

(J): MEDICAL SERVICES

The following medical bills were submitted by Petitioner:

P x 1 - Chicago Hand and Orthopedic Surgery Center - $1,648.00 (balance owed)
P x 2 - Midwest Hand Surgery - $3,554.00 (balanced owed)
P x 3 - Progressive Medical Center - $320 (M.D. visits) $1,605.00 (PT visits)
P x 6 - Elmhurst Hospital - $420.00 (balance owed)

Total: $7,547.00

The medical records from Chicago Hand and Orthopedic Surgery Center, Midwest Hand Surgery, Adventist Glen Oaks Hospital and Progressive Medical Center confirm that the Petitioner's current condition of ill being is related to the trauma his sustained to his left hand. Dr. Papierski opined that scarring at the ganglion cyst surgery site led to additional complications.

As noted above, Dr. Fetter's IME was completed prior to Petitioner's examination by Dr. Papierski and prior to the results of the diagnostic tests.

The Arbitrator finds that the evidence, considered as a whole, supports a finding that the disputed medical treatment was reasonable and necessary. Respondent is ordered to pay for the expense of all medical treatment related to Petitioner's left hand injury and subsequent complications to his left arm and left shoulder.

(K): PROSPECTIVE MEDICAL CARE

Petitioner testified as to the mechanism of his injury, his medical treatment to date and the diagnosis by Dr. Papierski of further treatment, primarily surgery. The medical records submitted corroborate the Petitioner's testimony as to his injury, the

complications arising out of the ganglion cyst surgery and the necessity of additional surgery. Dr. Papierski prescribed tenolysis/tenosynovectomy of the left ring finger and left ulnar nerve transposition, sub muscular. (P x 1). Dr. Papierski prescribed this once the electrodiagnostic tests of Petitioner's left hand were completed. Dr. Papierski placed Petitioner on restricted duties pending completion of the surgery. Petitioner, on the day of his testimony, complained that he still experiences pain in his left hand and inability to fully extend his fingers. The objective medical testing revealed that the Petitioner sustained a left hand contusion to the palm resulting in the aggravation of a cyst. The surgical procedure to remove the cyst caused scarring resulting in Petitioner's current condition.

The Arbitrator finds the treatment Dr. Papierski is recommending, tenolysis / tenosynovectomy of the left ring finger and left ulnar nerve transposition, is reasonable and necessary to cure the Petitioner of his work related injury and therefore awards the Petitioner prospective medical treatment.

(L): TEMPORARY TOTAL DISABILITY BENEFITS

Petitioner testified that he was injured during the course of his employment with Respondent. Petitioner sought medical treatment with Dr. Ramsey Ellis who performed surgery to remove a ganglion cyst in his left palm. Petitioner, unfortunately, developed complications from the surgery causing scar tissues and fibrosis limiting the use of his left hand. Petitioner testified that he did not agree with Dr. Ellis releasing him without restrictions on February 19, 2016. Petitioner was not in agreement because his left hand injury had not improved and he began to have pain radiating up his left arm to his shoulder.

Petitioner was referred by Dr. Henriquez at Progressive Medical Center by Dr. Papierski and continued to receive physical therapy for his shoulder at Progressive Medical Center. Petitioner testified that he was placed on restriction by Dr. Henriquez during the course of his physical therapy and treatment at Progressive Medical Center. (P x 12). In addition, once Dr. Papierski received the results of the diagnostic tests, he restricted the Petitioner to 10lb lifting restrictions on August 17, 2016.

Petitioner testified that he was terminated by Respondent in February 2016. He was informed by human resources that his department was to be shut down. Petitioner testified and is aware that his department has not been shut down. Petitioner was placed on restrictions by Dr. Roland Henriquez on February 20, 2016 of "right hand use only until Petitioner was seen by a hand specialist". (P x 12). Petitioner testified that he received maybe four TTD check that totaled $240 or $280 per week.

Petitioner's attorney requested that Respondent issue TTD payments to Petitioner, but no TTD benefits were issued for the majority of the period from February 20, 2016 through November 2, 2016. Petitioner is requesting TTD from February 20, 2016 through November 2, 2016, minus any credit to the Respondent. Petitioner is also requesting ongoing TTD until the surgery prescribed by Dr. Papierski is authorized and

Petitioner recovers. Petitioner is requesting TTD in the amount of $439.91 per week for a total of 37 3/7 for the periods from 12/4/2015 through 12/10/2015 and from 2/20/2016 through 11/2/2016.

The Arbitrator finds Petitioner's claim that he is unable to work because of his restrictions and need for surgery is supported by the evidence in the record. Accordingly, the Arbitrator finds the Petitioner is entitled to the disputed TTD benefits.

(M) PENALTIES / FEES

The Petitioner testified that the Respondent refused to pay TTD as required by the Act. Further, Petitioner testified that the TTD checks he did receive were in the amount of $240 or $280, less than the minimum amount of $286.00 as required under the Act.

Section 19(1) provides that the Arbitrator or Commission shall award additional compensation when the delay is unreasonable and when Respondent does not show just or reasonable cause for the delay, 19(1) penalties are mandatory. Smith v. Industrial Commission, 170 Ill. App.3d 626, 525 N.E.2d 81, 121 Ill.Dec. 275 (1988). In Smith, the Appellate Court for the Third District held that Section 19(l) provides that the Industrial Commission shall award additional compensation when the delay in payment is unjust or unreasonable. Id at 279. The Court in Smith stated that Section 19(l) provides that the Industrial Commission shall allow additional compensation of $10.00 per day for each day that weekly compensation is withheld, up to a limit of $2,500.00, when an employer or its insurance carrier delays the payment of compensation without good or just cause. A delay of 14 days creates a rebuttable presumption of unreasonable delay. Id at 279. Section 19(1) has since been amended to $30.00 per day with a limit of $10,000. In the instant case, the Respondent has not provided any reasonable explanation for denying TTD or medical treatment. The Illinois Court has held that the reasonableness of a delay in payment is a factual question left for Commission to resolve. Consolidated Freightways, Inc. v. Industrial Com., 136 Ill.App.3d 630, at 633, and 483 N.E.2d 652, 91 Ill.Dec. 306 (1985). In the present case, the delay by the Respondent is unreasonable and vexatious.

The Arbitrator finds that the Respondent is responsible for 50% of all awarded unpaid temporary total disability benefits, unpaid medical benefits as provided in Section 19(k) of the Act. The Arbitrator finds that the Respondent is responsible for 20% of all awarded unpaid temporary total disability benefits, unpaid medical benefits as provided in Section 16 of the Act. The Arbitrator finds that the Respondent is responsible for $10,000.00 as provided in Section 19(l) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID LOVELAND,

Petitioner,

vs. NO: 15 WC 21134

THE RESERVES NETWORK,

18IWCC0141

Respondent.

DECISION AND OPINION ON REVIEW

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

Findings of Fact and Conclusions of Law

The Commission adopts the Arbitrator's Findings of Fact except for the section entitled Arbitrator's Credibility Assessment. The Commission further disagrees with the Arbitrator's Conclusions of Law and reverses the Arbitrator's award of temporary total disability and prospective medical care for the reasons stated herein.

Arbitrator's Credibility Assessment

The Commission disagrees with the Arbitrator that Petitioner was merely a poor historian insofar as his past medical history was concerned and instead finds Petitioner misled Dr. Salehi and was purposefully evasive during cross examination. In 2011, when Petitioner consulted Dr. Syed, he gave a history of chronic back pain beginning with his initial injury as a teenager and he reported flare ups "from time to time." (Px7) While Petitioner initially reported to MedWorks Occupational Health he had an injury to his lower back in the past that occurred in the 1990s while chopping down a tree, he did not share that history with Dr. Salehi or during his testimony.

At Petitioner's first consultation with Dr. Salehi he reported he had two "bulging discs in 2011," he had "only back pain" at that time and that it mostly subsided, he only had occasional minimal pain until this injury, the pain "is much worse" and "now goes down the legs." The Commission finds the history Petitioner gave to Dr. Salehi was refuted by the findings of the June 4, 2011 lumbar spine MRI and the July 20, 2011 therapy note wherein Petitioner reported "he had an MRI which showed multiple-levels of herniated discs." Also, Dr. Syed's treatment records document multiple complaints of leg pain in 2011, e.g., May 21, 2011 (back pain "from his neck to his legs), June 9, 2011 (bilateral leg weakness), July 25, 2011 (pain traveling down his leg), September 1, 2011 (a letter of medical necessity for a TENS device for bilateral lower extremities' pain with numbness), thus Petitioner shared a selective history with Dr. Salehi.

Although Petitioner testified he had medical treatment in 2011 and 2012, when asked on cross-examination whether he had also had a back injury at the age of 18, Petitioner answered "I don't know where you got that from." In follow-up, Petitioner was asked "if Dr. Syed's notes of May 24, 2011 indicated 'at age 18 had back issue with axe missing a tree trunk, with pain for two weeks,' do you recall that?" Petitioner responded, "No." The Commission finds Petitioner's lack of recall is simply not credible in light of the MedWorks' history and the flare-ups he reported to Dr. Syed that occurred since his initial back injury.

Conclusions of Law

With respect to issue (F) and whether Petitioner established a causal connection between his undisputed work accident of December 11, 2014 and his current lumbar spine condition of ill-being, the Commission agrees with narrowing the analysis to whether the accident aggravated Petitioner's pre-existing lumbar spine condition. The Commission, however, draws different conclusions than the Arbitrator. A claimant may establish a causal connection in such cases if the claimant can show that a work-related injury played a role in aggravating his preexisting condition. *Mason & Dixon Lines, Inc. v. Industrial Comm'n*, 99 Ill. 2d 174, 181, 457 N.E.2d 1222, 75 Ill. Dec. 663 (1983). Petitioner in the subject case, however, failed to prove that he sustained more than a temporary aggravation of his preexisting condition.

The Commission finds the Arbitrator's reliance upon *Sisbro, Inc. v. Indus. Comm'n (Rodriguez), 207 Ill. 2d 193, 797 N.E.2d 665* is misplaced because the Petitioner failed to prove more than a flare up of his chronic back pain. The instant record is replete with documentation confirming Petitioner's longstanding chronic lumbar back condition and pre-existing disc

herniations confirmed by MRI. The records also confirm Petitioner was referred in August 2011 for follow-up with "pain management and orthopedics for surgery" and his medical treatment in 2011 was thwarted by "insurance limitations." (Px7, pp. 27, 37) Further, Petitioner was referred to Loyola Center for Health at Homer Glen on August 20, 2012 for "L4/5, L5/S1 ESI and facet injections bilaterally" and to be evaluated and treated for pain. Petitioner testified he had injections with Pain Management Specialists of St. Joe. (T, p. 37) There is no evidence in the record of other lumbar back treatment between August 2012 and the subject date of accident, December 11, 2014.

There is, however, evidence Petitioner's diagnostic findings improved between June 2011 and January 2015. Dr. Mather testified after reviewing the June 4, 2011 lumbar spine MRI, and comparing the actual images to the actual January 21, 2015 images, both herniations had markedly improved from 2011 to 2015 and both L4-L5 and L5-S1 were markedly smaller on the 2015 MRI. (Rx1, p. 23)

Dr. Salehi testified whether the size of the disc was changed or not, the issue was whether the disc was asymptomatic before and symptomatic after "you twist in a wrong way." (DeptT, p. 24)

Dr. Mather addressed at least one objective way to determine if a disc is symptomatic. On physical exam Dr. Mather found Petitioner had no leg pain complaints on straight leg raise test which would "go against a symptomatic disc herniation." (Rx1, p. 20) Dr. Salehi's office notes comport documenting the Petitioner complained of back pain only on straight leg raise. (Px4)

In addition, Petitioner testified subjectively he had pain in his back prior to December 11, 2014 albeit it was "very minimal, like a one or a two." The Commission infers the back pain was an indication Petitioner's disc or discs were symptomatic before the subject work accident. Petitioner testified the pain rating was different. When asked after December 11, 2014 "did your pain remain the same?" Petitioner responded, "It went up." ...I would have pain. It was like a seven or eight, but when I would lay down and was less active it was like a five or six." (T, pp. 21, 22)

While initially Petitioner's back pain might have gone up after the subject "tweaking" incident, the Commission also finds this comports with Petitioner's history to Dr. Syed, that he had "flare ups" from time to time. The record is also replete with references to Petitioner's continued strenuous physical activities after the subject accident further impugning the veracity of the Petitioner's testimony, in this instance, regarding the extent of his continued subjective pain levels.

The ATI records confirm Petitioner had increased pain after shoveling snow documented on two occasions, February 3, 2015 and February 4, 2015. Dr. Salehi also testified that on May 1, 2015, Petitioner's legs gave out while trying to mow his lawn. Dr. Salehi admitted that mowing his lawn was a type of event that could cause Petitioner to have problems in his back. On June 26,

2015 Petitioner reported to Dr. Salehi "I've been doing things that I shouldn't have been doing." Dr. Salehi conceded he did not know what Petitioner meant. (DepT, pp. 38-40)

Moreover, Petitioner testified his pain since the 2014 injury is in his left lower back and after the 2011 injury his pain was in his right lower back. (T, pp. 22, 23) The Petitioner's testimony does not comport with the histories in Dr. Salehi's or Integrated Pain Management's office notes or with Dr. Syed's pre-accident notes. The post-accident medical records do not document solely left-sided back pain complaints; nor do the 2011/2012 records document solely right-sided back pain complaints. In fact, there are only a few post-accident therapy records documenting complaints of left pain greater than right, however, no one-sided back complaints. (Px4, Px5, Px7) Thus the Commission is not persuaded by the Petitioner's distinction between his lumbar spine pain after his 2011 flare-up and after he "tweaked" his back at work.

When asked if Petitioner's herniation was aggravated, Dr. Salehi testified he did not have an "MRI before to compare. So, he told me he had two bulging discs before. So, I can't comment on whether the size of it was changed or not." (Px2, pp. 23-24) Dr. Salehi later testified that "Bulges usually means smaller than herniations." (DepT, p. 32)

Dr. Salehi attributed the Petitioner's low back pain to degenerative disc disease, with or without herniation. The fusion part of the surgery is designed to take "care of the back." (T, pp. 16-18) Dr. Salehi did not know, however, whether the Petitioner's degenerative disc disease was present in 2011, "not having a prior MRI." (Px2, p. 29) Dr. Salehi also testified he could not answer whether the Petitioner had acute findings after the work incident on his MRI exam, "again, not having seen any prior MRI." (DepT, p. 31) Therefore, the Commission is not persuaded Dr. Salehi's causation opinion was based on an accurate understanding of Petitioner's pre- and post-accident condition.

According to Dr. Salehi, the hemilaminectomy part of the surgery "will take the pressure off the nerves going down the legs" and the need for surgery was caused by the work injury "based on the history provided." Dr. Salehi clarified..." this patient was working at his job, wasn't actively seeking treatment as far as I know and had this accident, and now he's having all these leg pains in addition to the lower back pain. So, it kind of supports the notion of aggravation." (Px2, pp. 25)

The Commission finds Dr. Syed's records belie Dr. Salehi's presumption that the Petitioner's leg pain was new since the subject accident. Dr. Salehi did not review the 2011 and 2012 treating records. Petitioner had leg pain in 2011 according to Dr. Syed's records as evidenced by the several afore-referenced entries in May, June, July and September 2011. (Px7) Therefore, the Commission finds Dr. Salehi's assumption regarding the etiology and onset of Petitioner's leg pain was incorrect.

The Commission also finds Dr. Salehi's assumptions regarding the Petitioner's work history was factually incorrect and as a basis for his causation opinion was also flawed. On cross-

examination Dr. Salehi testified it was his assumption Petitioner was working in a full-duty capacity up to December 11, 2014, he had been since 2012 and Petitioner was working in 2012 and 2013. (Px2, pp. 32, 34) Dr. Salehi admitted he did not ask Petitioner about his work history prior to his employment with Respondent. (Px2, pp. 32-33) Petitioner testified he worked for Respondent stocking tissue boxes in cases and closing the flap, for "about a month." (T, pp. 11, 12) Petitioner worked from November 19, 2014 until December 11, 2014, a period just over three weeks. (Rx1, p. 43) Prior to the injury, he was working in a position that required a light physical demand level. (Px6) Prior to working for Respondent, Petitioner had not worked for seven or eight years and "stayed home with the kids." (Arb Dec, p. 7, Rx1, p. 7 & RDepx2)

Therefore, the Commission finds Dr. Salehi's causation opinion 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.)

The Commission, therefore, disagrees with the Arbitrator's finding that Dr. Salehi is more credible than Dr. Mather. The Commission is also not persuaded Petitioner's pre-accident physical capabilities were greater than his post-accident limitations when he was examined by Dr. Mather. Upon review of the January 21, 2015 lumbar spine MRI, Dr. Mather noted there was no left-sided nerve root compression and the Petitioner was complaining of left-sided pain. (Rx1, pp. 16-17) Dr. Mather testified there was not any nerve root compression on either side. (Rx1, p. 19)

Dr. Mather did not feel that Petitioner needed a bilateral discectomy and fusion at L4-S1, or that Petitioner needed any further medical treatment and he could return to work. Considering all his positive Waddell findings during simulated axial rotation of the lumbar spine and axial compression, vibratory and pinprick testing, Dr. Mather did not think Petitioner was a candidate for surgery and he could return to work. (Rx1, pp. 10-14, 24)

The Commission also notes the Petitioner testified he has been diagnosed with diabetes and neuropathy since the time of the work-related incident and he was using a cane because of those medical conditions. On physical exam Dr. Mather noted Petitioner had no reflex on the right ankle and he testified that could be absent for many reasons including diabetes. (Rx1, pp. 12, 13)

After reviewing all the evidence including the medical records and the testimonies of Petitioner, Dr. Salehi and Dr. Mather, the Commission is not persuaded that the work accident aggravated or accelerated Petitioner's pre-existing condition to warrant surgery.

Based upon all the evidence contained in the record and relying upon the records of claimant's pre-accident treating physicians and the opinion of Dr. Mather, the Commission finds the Petitioner sustained a temporary aggravation of his preexisting condition and his condition returned to baseline by June 24, 2015, the date Dr. Mather opined that Petitioner was at maximum medical improvement.

Dr. Mather's opinion notwithstanding, the Commission is bound by the trial stipulations. See *Walker v. Industrial Comm'n*, 345 Ill. App. 3d 1084, 1087-88, 804 N.E.2d 135, 138, 281 Ill. Dec. 509 (2004) (statement by employer in its request for a hearing that employee was temporarily totally disabled for 84 weeks was binding on the employer.) Although Dr. Mather opined Petitioner reached MMI by June 24, 2015, Respondent stipulated to lost time benefit entitlement until July 14, 2015. The Commission infers Respondent's stipulation was based upon the date of termination of TTD benefits after receipt and notice of Dr. Mather's June 24, 2015 addendum report. The Commission finds the stipulation is not an admission but rather consistent with the findings and Conclusions of Law contained herein.

With respect to issue (K) "Is Petitioner entitled to prospective medical care?" the Commission disagrees with the Arbitrator's award of prospective medical in the form of a return visit to Dr. Salehi, and the previously recommended surgery, assuming the doctor still finds this surgery to be appropriate and noting Petitioner had not seen Dr. Salehi in over a year. Relying upon Dr. Mather's opinion Petitioner was at MMI by June 24, 2015, the Commission vacates the Arbitrator's award of prospective medical.

With respect to issue (L) "Is Petitioner entitled to temporary total disability (TTD) benefits, the Commission disagrees with the Arbitrator's award of benefits, from January 20, 2015 through October 19, 2016, a total period of 95 2/7 weeks. Respondent stipulated Petitioner was temporarily totally disabled between January 20, 2015 through July 14, 2015, a period of 25 1/7 weeks and the Arbitrator also awarded TTD benefits from July 15, 2015 through the hearing date October 19, 2016, an additional period of 66 1/7 weeks. The Commission vacates the Arbitrator's award of TTD benefits from July 15, 2015 through October 19, 2016. The Commission finds Petitioner was temporarily totally disabled between January 20, 2015 and July 14, 2015.

IT IS THEREFORE ORDERED BY THE COMMISSION that the §19(b) Decision of the Arbitrator, filed November 7, 2016 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION the Arbitrator's award of TTD benefits from July 15, 2015 through October 19, 2016 is hereby vacated and that Respondent shall pay to the Petitioner the sum of $330.00 per week for a period of 25-1/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $542.00 for medical expenses under §8(a) and as provided in §8.2 of the Act so long as said amount does not represent balance billing.

IT IS FURTHER ORDERED BY THE COMMISSION the Arbitrator's award of prospective medical in the form of a return visit to Dr. Salehi, and the previously recommended surgery, is vacated.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: MAR 9 - 2018
KWL/bsd
O: 01/08/18

Kevin W. Lamborn

Michael J. Brennan

DISSENT

I respectfully dissent from the opinion of the majority and would affirm and adopt the Arbitrator's Decision in its entirety. After considering the totality of the evidence, I believe Petitioner met his burden of proving that the December 11, 2014 work accident at the very least aggravated or exacerbated his pre-existing condition. Therefore, I do not believe there is a reasonable basis for the majority to overturn the Arbitrator's findings regarding the issues of causation, TTD, and prospective medical.

The December 11, 2014 work accident is undisputed. It is also undisputed that Petitioner injured his back due to the work accident. While Petitioner admitted to experiencing minor back pain prior to the work accident, the medical records clearly support a finding that the work accident aggravated or exacerbated Petitioner's pre-existing back condition. The records show that Petitioner sought treatment for pain in his back and neck in May 2011. At that time, the doctor noted that Petitioner said he had suffered from back pain since the age of 18 and had experienced intermittent flare-ups since then. There is no evidence that Petitioner pursued any treatment for his lumbar spine since August 2012.

Petitioner testified that prior to the work accident, he experienced minimal back pain rating a 1 or 2 on a scale of 1-10. There is no evidence that Petitioner experienced radicular symptoms in either leg from his last known date of treatment in August 2012 until this work accident. Immediately after the work accident Petitioner described his pain as a level 9 on a scale of 1-10. During the hearing, Petitioner testified that his current pain level was a 6 or 7 on a scale of 1-10. Petitioner also testified he still experienced significant radicular pain in both legs. The medical records reveal that Petitioner suffered from radicular pain into his lower extremities in 2011 and 2012; however, Respondent presented no evidence that Petitioner experienced any radicular pain between August 2012 and this work accident. Likewise, although the pre-accident medical records indicate Petitioner told a physical therapist that he wanted to undergo surgery but could not due to insurance issues, there is no evidence any doctor recommended Petitioner undergo back surgery prior to the December 2014 work accident.

Finally, I agree with the Arbitrator's determination that Dr. Salehi, the treating doctor, is more credible than Dr. Mather, Respondent's IME doctor. While Dr. Salehi was not privy to the full extent of Petitioner's pre-accident treatment for his lumbar spine, he knew the facts most pertinent to determining causation for this work accident. Dr. Salehi knew Petitioner suffered a lumbar injury in 2011, that prior to the date of accident Petitioner suffered from occasional bouts of minimal back pain, that Petitioner was able to work full duty for Respondent prior to the work accident, and that Petitioner's lumbar pain and related symptoms drastically increased immediately following the work accident. The fact that Dr. Salehi did not review the 2011 lumbar MRI is immaterial given the facts. I note that Dr. Salehi is not the only doctor who believes Petitioner needs surgery. Dr. Xia, the treating pain management doctor, also recommended surgery.

On the other hand, Dr. Mather initially concluded Petitioner did require surgery, albeit a microdiscectomy instead of the two-level fusion Dr. Salehi recommended. Dr. Mather also initially prescribed a 10-pound lifting restriction. After reviewing the 2011 MRI, Dr. Mather changed his opinion with little explanation and opined not only that Petitioner does not need *any* surgery, but also that Petitioner attained MMI and is suddenly able to return to work without restrictions. Dr. Mather testified that an aggravation of Petitioner's pre-existing condition could result from Petitioner's mechanism of injury. The doctor also admitted that it is possible for a patient with disc herniation at L4-L5 and L5-S1 to have subjective complaints of low back and bilateral leg pain.

For the forgoing reasons, I would affirm the Arbitrator's well-reasoned decision.

Thomas J. Tyrrell

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

LOVELAND, DAVID
Employee/Petitioner

Case# **15WC021134**

RESERVE NETWORK
Employer/Respondent

18IWCC0141

On 11/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% 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:

1067 ANKIN LAW OFFICE LLC
SCOTT GOLDSTEIN
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

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

David Loveland
Employee/Petitioner

v.

Reserve Network
Employer/Respondent

Case # 15 WC 21134

Consolidated cases: N/A

18IWCC0141

An *Application for Adjustment 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 **10/19/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **12/11/14**, 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 **$1,480.00**; the average weekly wage was **$370.00**.

On the date of accident, Petitioner was **35** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of **$8,877.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8,877.00**.

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, pursuant to the medical fee schedule, of $419.00 to Integrated Pain Management Lombard, as provided in Sections 8(a) and 8.2 of the Act, so long as said amount does not represent balance billing.

Temporary Total Disability

Respondent stipulated Petitioner was temporarily totally disabled from January 20, 2015 through July 14, 2015. Arb Exh 1. This is a period of 25 1/7 weeks. The Arbitrator finds Petitioner was also temporarily totally disabled from July 15, 2015 through the hearing of October 19, 2016, a period of 65 6/7 weeks. The Arbitrator finds Petitioner's temporary total disability rate to be $330.00 per week.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 1/20/15 through 10/19/16, and shall pay the remainder of the award, if any, in weekly payments.

Prospective Medical Care

Respondent shall authorize and pay for prospective care in the form of a return visit to Dr. Salehi along with the surgery previously recommended, so long as the doctor still finds this surgery to be appropriate.

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

11/7/16
Date

ICArbDec19(b)

NOV 7 - 2016

Summary of Disputed Issues

Respondent stipulated to accident, notice and temporary total disability from January 20, 2015 through July 14, 2015. Arb Exh 1. According to the Request for Hearing form (Arb Exh 1), the disputed issues include causal connection, medical, temporary total disability from July 15, 2015 through the hearing of October 19, 2016 and prospective care, with Petitioner seeking back surgery, as recommended by Dr. Salehi.

Arbitrator's Findings of Fact

Petitioner testified he is not currently employed. As of his December 11, 2014 accident, he had worked for Respondent for about a month. He worked in a factory setting. His job consisted of putting boxes of tissue in cases and sending the packed cases down a line.

Petitioner acknowledged having lower back problems and undergoing lower back treatment prior to the accident. He recalled injuring his back in 2011, undergoing an MRI in June 2011, undergoing injections in approximately February 2012 and resuming full duty thereafter. He denied being under any active treatment for his low back during the months preceding the December 11, 2014 accident. He acknowledged experiencing minimal low back pain, which he would rate as 1 or 2 on a scale of 1 to 10, at the time of the accident. He testified the accident caused his pain level to increase substantially.

Certified records from Liberty Medical Center (PX 7) show that Petitioner sought treatment for pain from his "neck down to [his] tailbone" at the Emergency Room at Morris Hospital on May 21, 2011. The examining physician noted that the onset of this pain "was around age 18" with subsequent intermittent flare-ups. On examination, the physician noted a limited range of cervical and lumbar spine motion with some associated spasm. The physician administered an injection of pain medication and directed Petitioner to follow up with his primary care physician in three to four days. Petitioner followed up with Dr. Syed on May 24, 2011, with the doctor ordering X-rays and laboratory studies. Petitioner returned to Dr. Syed on May 31, 2011, with the doctor indicating he was "still" complaining of his shoulder. The doctor assessed cervical radiculopathy and back pain. He prescribed MRIs of the cervical and lumbar spine along with physical therapy. Petitioner underwent a lumbar spine MRI at Morris Hospital on June 4, 2011. The radiologist noted a broad-based disc bulge with central disc protrusion, resulting in mild impingement of the origins of the L5 nerve roots bilaterally at L4-L5 and a broad-based disc bulge with a large central/right paracentral disc extrusion resulting in compression of both S1 nerve root origins, right greater than left, and also resulting in moderate right foraminal stenosis with mild impingement of the exiting right L5 nerve root. Petitioner returned to the Emergency Room on June 8, 2011. The examining physician noted a complaint of 9/10 lower back pain. He referenced an MRI which he described as showing "multiple herniated discs." He prescribed Naproxen and directed Petitioner to see Dr. Quo, an

orthopedic surgeon, and to follow up with Dr. Syed. On June 9, 2011, Dr. Syed noted that Petitioner reported experiencing low back pain "when working on forklift." He also noted that Petitioner had returned to the Emergency Room the previous day. He described Petitioner as being "unable to sit and stand without pain." He noted the MRI results, administered a Toradol injection and recommended evaluation by an orthopedic surgeon and pain management. The following day, Dr. Syed referred Petitioner to Dr. Hassain, referencing the MRI results and a 2 to 3-week history of back pain with a recent aggravation. On June 20, 2011, Dr. Syed noted that Petitioner was still experiencing 9/10 neck and back pain and was in the process of scheduling an appointment with an orthopedic surgeon. He prescribed Norco and Flexeril and directed Petitioner to avoid lifting any weight. On June 27, 2011, Dr. Syed noted that Petitioner was no better and had been unable to see an orthopedic surgeon "due to insurance limitations." He refilled the Norco and Flexeril and indicated he planned to admit Petitioner to a hospital if his condition worsened. On July 11, 2011, Dr. Syed issued a note indicating Petitioner could not return to work until July 25, 2011. On July 20, 2011, Petitioner underwent a physical therapy evaluation at Morris Hospital, with the therapist noting a history of back pain dating back to age 18 and the onset of neck pain with lifting a box of pillows at work in May 2011. The therapist indicated that Petitioner reported trying to lift his child after the work incident and then experiencing pain radiating from his neck down to his back. She also noted that Petitioner was currently off work and wanted to undergo surgery but was unable to find a doctor who would accept his insurance. On July 25, 2011, Dr. Syed noted that Petitioner had started experiencing "pain traveling down his leg" since beginning therapy. He prescribed Vicodin, Flexeril, ice packs, rest and continued therapy. He also referred Petitioner to pain management. On August 11, 2011, Dr. Syed referred Petitioner to Dr. Michalow, an orthopedic surgeon, referencing the MRI results and asking Dr. Michalow to evaluate and treat Petitioner. Petitioner was discharged from physical therapy on August 12, 2011, with the therapist noting a positive response to E-stimulation and Dr. Syed recommending a home TENS unit. The therapist indicated Petitioner did not return after August 12th. On August 23, 2011, Dr. Syed noted that Petitioner had recently been admitted to a hospital due to a right lung mass/pneumonia. He diagnosed both pneumonia and back pain. He directed Petitioner to discontinue narcotics, take Ibuprofen and follow up with an orthopedic surgeon. On September 1, 2011, Dr. Syed signed a Medicaid-related "letter of medical necessity" indicating Petitioner was using and required a TENS unit due to chronic pain in both lower extremities with associated numbness. The doctor also indicated that other conservative measures, including medication and therapy, had proved unsuccessful. On August 15, 2012, Petitioner saw Dr. Kouloumberis, apparently at Dr. Syed's referral, with that doctor recommending bilateral epidural steroid and facet injections at L4-L5 and L5-S1.

Petitioner testified that, immediately prior to his accident of December 11, 2014, he left his work station and headed toward Respondent's break room with the intention of taking a break. He lifted a gate, stepped on an electric cord cover, lost his footing on the cover, twisted his back and then managed to catch himself. He testified his foot slipped off the cover.

Petitioner testified he immediately reported the accident to his supervisor and was sent to MedWorks, a company clinic, where he saw Dr. Xia.

The records from MedWorks Occupational Health reflect that Petitioner saw Dr. Kimberly Middleton on December 11, 2014, with the doctor recording the following history:

> "This is a new injury for a patient who states he stepped over a walk over step and slipped off the step. As he tried to catch himself, he 'tweaked' his low back. He felt a slight popping sensation. He states he has pain which he rates 9/10. He states he injured his lower back in the past in 1990s while chopping down a tree. He describes it as tweaking his back."

Dr. Middleton noted that Petitioner appeared uncomfortable and exhibited a "left lateral shift and positive SI joint tenderness." She also noted tenderness with palpation along the paravertebral regions near L2-S1 bilaterally, left greater than right. She indicated Petitioner was unable to perform range of motion testing "due to severe pain."

Dr. Middleton obtained lumbar spine X-rays, which demonstrated no fractures or dislocations. She diagnosed an acute lumbar sprain with spasms and left SI joint dysfunction. She prescribed Ibuprofen, an SI belt to be worn during the day, Norco and Flexeril. She instructed Petitioner to stay off work and return to the clinic the following Monday. PX 3.

On December 15, 2014, Petitioner returned to MedWorks and saw Patrice Muhammad, a physician's assistant. Muhammad noted slight improvement but a complaint of a pulling sensation in the lower back with prolonged standing. On examination, she noted a reduced range of lumbar spine motion, mild left SI joint tenderness, negative straight leg raising bilaterally, slightly positive Fabere's testing on the left and a slightly antalgic gait. She directed Petitioner to continue using the belt and taking and medication. She released Petitioner to light duty with no pushing, pulling or lifting over 20 pounds and directed him to return to MedWorks on December 22nd. PX 3.

On December 22, 2014, Petitioner returned to MedWorks and saw Dr. Xia. The doctor indicated Petitioner was still complaining of lower back pain, along with "on and off radiation of tingling and numbness down to both legs around the ankle," and was tolerating light duty.

Dr. Xia described Petitioner's gait as normal. He noted a restricted range of lumbar spine motion and straight leg raise testing bilaterally at 45 degrees reproducing the low back pain. He prescribed physical therapy and directed Petitioner to continue taking the Norco and Motrin. He allowed Petitioner to continue light duty and directed him to return on January 5, 2015. PX 3.

Petitioner underwent an initial physical therapy evaluation at ATI on December 31, 2014, with the evaluating therapist noting a history of the work accident and complaints of

constant low back pain, left greater than right. The therapist described Petitioner's gait as mildly antalgic. PX 6.

Petitioner saw Dr. Xia again on January 5, 2015. The doctor's examination findings were unchanged. He recommended a lumbar spine MRI and took Petitioner off work pending the MRI results.

A therapy note dated January 6, 2015 reflects that Petitioner reported feeling worse secondary to bending to pick something up at work and feeling a "couple pops" in his back. Petitioner reported having seen a doctor the day before, with the doctor recommending an MRI. PX 6.

The MRI, performed without contrast on January 21, 2015, demonstrated a moderate sized right protrusion at L5-S1, producing a "severe right lateral recess stenosis" and displacing the thecal sac inferiorly, and a small central protrusion producing mild central stenosis at L4-L5. PX 4.

On January 23, 2015, Petitioner returned to MedWorks and again saw Dr. Middleton. The doctor noted persistent symptoms and indicated that Petitioner "has herniated lumbar disc." She prescribed physical therapy and referred Petitioner to Dr. Salehi. She released Petitioner to light duty with no lifting, pushing or pulling over 10 pounds and no repetitive bending or twisting. PX 3.

Petitioner testified that, about two or three weeks after the accident, he resumed working for Respondent on a light duty basis. This light duty continued for about one week. It consisted of watching a line to check for quality control. Petitioner testified he subsequently stopped performing light duty at Respondent and began receiving temporary total disability benefits. At Respondent's direction, he performed community service work for two entities while receiving these benefits. He worked at the first entity, Salvation Army, for about one week. He then moved on to Habitats for Humanity, where he worked for about three weeks. He stopped going to Habitats for Humanity because he was being asked to perform tasks, such as carrying benches, that exceeded his then-current 10-pound restriction.

A physical therapy progress note of January 28, 2015 reflects that Petitioner was still experiencing low back pain but was now also experiencing "even worse leg pain."

On February 6, 2015, Petitioner saw Dr. Salehi. The certified records from this physician include a medical history form which contains two sets of handwriting. The form reflects that Petitioner complained of 8/10 pain in his lower back, hips and knees that started on December 11, 2014. The accident of that date is described as follows: "foot got caught over electrical walkover – 'tweaked' back." In response to a question asking whether Petitioner had similar symptoms previously, someone wrote: "yes – occ. flare up of LBP – never legs.". A pain diagram shows highlighting around the buttocks and backs of the legs to the knees, with the notation: "back greater than leg, left greater than right." PX 3.

Dr. Salehi's initial history of February 6, 2015 reflects that Petitioner complained of 8/10 lower back pain radiating to his hips and legs to the calves, as well as leg tingling and weakness, secondary to a work accident of December 11, 2014. The doctor also noted a history of "back pain beginning in 2011 which began while he was working outside." He stated that Petitioner was "told he had two bulging discs for which he had injections in 2012" and that Petitioner described his subsequent back pain as only occasional and minimal until the December 2014 accident. He noted that Petitioner had resumed light duty the previous day.

On initial examination, Dr. Salehi noted diffuse spinal tenderness, a reduced range of motion, straight leg raising positive in the back only, bilaterally, and abnormal heel/toe walking bilaterally.

Dr. Salehi indicated he reviewed the January 21, 2015 MRI. He interpreted the film a showing significant disc degeneration of L5-S1, a centrally herniated disc compressing both traversing S1 nerve roots, a possible extruded component of the herniation to the left, mild retrolisthesis of L5 over S1 and a centrally herniated disc at L4-L5 resulting in moderate bilateral lateral recess stenosis. Dr. Salehi related Petitioner's back pain and radicular symptoms to the work accident. He recommended continued physical therapy and one or two transforaminal epidural steroid injections at L5-S1. He directed Petitioner to return to him after the injections and indicated he would give consideration to surgery if Petitioner remained symptomatic. He released Petitioner to sedentary duty with no lifting, pushing or pulling over 10 pounds, no bending or twisting and the ability to alternate sitting and standing every 30 to 45 minutes as needed. PX 4.

On February 6, 2015, Petitioner also saw Dr. Tian Xia at Integrated Pain Management in Joliet. The doctor noted a referral from Dr. Salehi. He recorded a history of the work accident and indicated Petitioner was performing light duty and deriving no benefit from physical therapy. The doctor also noted that Petitioner "had an issue back in 2012" and underwent two injections at that time.

On examination, Dr. Xia noted limited flexion and extension, an inability to walk on the heels and toes, positive straight leg raising bilaterally and loss of sensation in the left L5/S1 dermatome. He described Waddell's signs as negative. He reviewed the MRI and indicated he agreed with Dr. Salehi's recommendation of injections. He prescribed various medications, including Tramadol, and recommended that Petitioner continue therapy. PX 5.

The following day, February 7, 2015, Dr. Xia administered a bilateral transforaminal epidural injection at L5-S1.

A physical therapy progress note of February 17, 2015 reflects that Petitioner reported experiencing only a couple of days of pain relief following the injection. PX 6.

Petitioner returned to Dr. Xia on February 27, 2015. The doctor noted that the injection provided "a few days of pain relief," after which the "pain came back with vegence [sic]." He indicated that Petitioner was performing light duty but that this duty consisted of mopping floors rather than desk work. He stated he had directed Petitioner to "return to desk job only."

Dr. Xia added Norco to the previous medication regimen and directed Petitioner to continue therapy. PX 5.

On March 4, 2015, Dr. Xia administered a second injection, again at L5-S1. PX 5.

Petitioner last attended physical therapy on March 11, 2015, with the therapist indicating that Petitioner was going to have surgery and that therapy was being placed on hold. In the discharge summary, the therapist indicated Petitioner "continues to present with impairments involving ROM, strength, flexibility, balance, joint mobility, soft tissue mobility, posture, gait, pain and weight bearing." PX 6.

On March 13, 2015, Dr. Xia reported that Petitioner "did not have much relief at all" following the second injection. He directed Petitioner to increase his Norco intake, start Opana and return to Dr. Salehi for "possible surgery." He indicated that Petitioner reported having stopped smoking three weeks earlier. PX 5.

Petitioner returned to Dr. Salehi on March 20, 2015. The doctor noted that Petitioner reported no benefit from the injections or therapy. He also noted that Petitioner was still in pain and felt "weak in both legs" but denied falling. He indicated that Petitioner reported having quit smoking a month earlier. He addressed treatment needs as follows:

> "Given he has failed conservative treatment and has been able to quit smoking, I recommend surgical intervention in the form of a left L4-S1 transforaminal lumbar decompression and interbody fusion and right L4-S1 hemilaminectomy."

He recommended that Petitioner stay off work, undergo a urine nicotine screen to confirm smoking cessation and return to him in four weeks. PX 4.

On April 24, 2015, Dr. Xia noted that Petitioner had not yet undergone surgery and that the insurance carrier was "getting a second opinion." He also noted that the Opana provided pain relief but that Petitioner had stopped taking it due to constipation. He reduced the Opana dosage, prescribed Promolaxin for constipation and prescribed a muscle relaxant and Neurontin. He indicated that Petitioner "would possibly need a discogram prior to surgery pending neurosurgeon opinion." PX 5.

Petitioner saw Dr. Salehi again on May 1, 2015, with the doctor noting ongoing back and leg pain as well as intermittent weakness in the legs. He noted that Petitioner reported falling

while mowing the lawn due to his leg giving out on him. He indicated that Petitioner was taking Opana ER and an "immediate release" per Dr. Xia and had not smoked since the last visit. He again recommended surgery and a pre-operative urine nicotine screening. He released Petitioner to desk work with no lifting, pushing or pulling over 10 pounds and no bending or twisting more than 3 times per hour. PX 4.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Mather on May 4, 2015. In his report of that date, Dr. Mather that Petitioner reported beginning to work for Respondent on November 19, 2014, having previously stayed "home with his kids" for seven or eight years, and injuring his back at Respondent on December 11, 2014 when his foot slipped off a foot-tall box containing electrical cords.

Dr. Mather described Petitioner as a "very vague" historian who reported undergoing a back MRI in 2011, while under Dr. Syed's care, but otherwise declining to discuss his pre-accident back condition.

Dr. Mather noted that Petitioner complained of low back pain and pain in both legs "all the way to the feet," along with numbness and weakness in both feet. He also noted that Petitioner reported having been released to light duty by Dr. Salehi the previous week.

Dr. Mather described Petitioner as "appearing to be quite comfortable" while sitting and discussing his history but rising out of the chair "with extreme difficulty" and complaining of severe tenderness "even to light touch around the lumbar spine." He noted a "markedly positive Waddell finding with simulated axial rotation of the lumbar spine and axial compression."

Dr. Mather described seated straight leg raising as completely negative for any pain behaviors. He also described Petitioner as having "completely lost the ability to detect any vibratory sense" in his legs. Vibratory testing was normal in the upper extremities.

Dr. Mather noted "no sensation in all dermatomes below the right knee" but indicated that Petitioner sharply withdrew his right foot with pinprick testing of the sole of that foot.

Dr. Mather noted complaints of excruciating pain with supine straight leg raising on the right at 80 degrees and on the left at 90 degrees. He indicated that Petitioner's left-sided pain was only in his back. He described hip range of motion testing as "exceedingly painful."

Dr. Mather indicated he personally reviewed the January 21, 2015 lumbar spine MRI films as well as various records from the occupational health facility and Drs. Salehi and Xia. He interpreted the MRI as showing a "right L5-S1 herniated disc" and a "very mild non-compressive bulge at L4-L5." He noted no left-sided nerve root compression.

Dr. Mather diagnosed Petitioner with a right L5-S1 disc herniation and "symptom magnification/psychogenic overlay." He addressed causation as follows:

> "It is my professional opinion that Mr. David Loveland could have sustained a right L5-S1 disc herniation as a result of a slip-and-fall injury on December 11, 2014. His MRI shows a right L5-S1 disc herniation."

He expressed a desire to review the 2011 lumbar spine MRI and Dr. Syed's records from 2011. He characterized the conservative treatment to date as reasonable and necessary but expressed concern about Petitioner's severe complaints and positive Waddell's findings when addressing treatment needs. He indicated that a paracentral disc herniation at L5-S1 would have produced right-sided symptoms and that Petitioner's "diffuse complaints, especially on the left side, as well as severe central back pain, do not make sense."

Dr. Mather recommended that Petitioner undergo a CT myelogram to see whether he in fact had any right-sided nerve compression. He indicated Petitioner "may need a right L5-S1 microdiscectomy" if in fact the CT myelogram showed right-sided nerve compression but disagreed with Dr. Salehi's recommendation of a two-level fusion. He found Petitioner capable of light duty, subject to a 10-pound lifting restriction, pending review of the 2011 MRI and records. Mather Dep Exh 2.

A May 29, 2015 note in Dr. Salehi's records reflects that the IME physician reported seeing no imaging and wanted Petitioner to undergo a CT myelogram. The note also reflects that Dr. Salehi disagreed with this and felt that "perhaps once the IME physician has seen the MRI he will agree that no further imaging is necessary." PX 4.

On June 5, 2015, Dr. Xia noted that Petitioner had stopped taking the Opana due to persistent constipation and was now experiencing "severe pain down to both legs." He described his examination findings as unchanged. He adjusted Petitioner's medications and stated: "in my opinion, he needs the surgery." PX 5.

On June 24, 2015, Dr. Mather issued an addendum. He revisited the issue of causation, indicating he had had an opportunity to review Petitioner's June 4, 2011 lumbar spine MRI images:

> "Mr. Loveland had on his MRI of June 4, 2011, a large central disc herniation at L4-L5 and a very large right L5-S1 disc herniation. The herniation is larger on the 2011 MRI than it was on the January 21, 2015 MRI, though both show significant right S1 nerve root compression. The herniation at L4-L5 is also markedly improved (comparing the 2011 MRI to the more recent January 21, 2015 MRI).
>
> This MRI indicates that this patient had a longstanding right L5-S1 disc herniation. It does not appear that he aggravated this herniation

> as a result of a slip and fall injury on December 11, 2014, as his MRI shows a smaller disc herniation than it was in 2011 (i.e., the herniation has shrunk). Additionally, the more recent MRI shows the L4-L5 central herniation is much smaller. It is now a very minor bulge at L4-L5."

Dr. Mather also revisited the issue of surgery: "I do not believe this patient requires surgery. There is certainly no left-sided nerve root compression to correspond with his complaints of pain down the left as well as right leg." He found Petitioner to be at maximum medical improvement and capable of resuming full duty. Mather Dep Exh 3.

On June 26, 2015, Dr. Salehi indicated that Petitioner was still experiencing constant back and bilateral leg pain. He also noted that Petitioner reported having fallen a couple of times since his last visit because he was "doing things [he] shouldn't have been doing." He further noted that Dr. Xia had taken Petitioner off Opana and that Petitioner was now taking a muscle relaxant and Gabapentin. He indicated that Petitioner had not resumed smoking.

Dr. Salehi noted that an independent medical examiner was recommending a myelogram but that he disagreed with this recommendation, "given the invasive nature of the testing and increased risk of infection as well as the fact that [Petitioner's] anatomic pathology is obvious on his MRI imaging." He indicated the examiner could write the order for the myelogram himself if he felt it should be done. He added Mobic to Petitioner's medication regimen and again recommended surgery and a pre-operative urine nicotine screening. He continued the previous work restrictions and directed Petitioner to follow up with Dr. Xia. PX 4.

Petitioner returned to Dr. Xia on July 10, 2015. The doctor noted that surgery had not been scheduled and that Petitioner "was ordered to have a myelogram," despite Dr. Salehi's disagreement with this. After re-examining Petitioner, he refilled the medication and described Petitioner as a surgical candidate. He described Waddell's signs as negative. PX 5.

Dr. Salehi testified by way of evidence deposition on December 8, 2015. PX 2. Dr. Salehi testified he is board certified in neurosurgery. He primarily operates on the spine. He was an assistant professor at Northwestern until 2005. PX 2 at 6.

Dr. Salehi testified he first saw Petitioner on February 6, 2015. He does not know who referred Petitioner to him. He wrote to an adjuster, Sue Harrison, after seeing Petitioner. PX 2 at 7. Petitioner reported tweaking his back at work on December 11, 2014, "when his foot got caught on an electrical walkover." Petitioner rated his back pain at 8/10 and also complained of leg tingling and weakness. Petitioner related experiencing back pain while working outside in 2011. Petitioner indicated that, after the 2011 event, he was told he had two bulging discs and underwent injections in 2012. Petitioner stated his back pain "mostly subsided" thereafter until the December 11, 2014 accident. PX 2 at 8-9. Petitioner denied other work injuries or car accidents. PX 2 at 9.

Dr. Salehi testified that, at the initial examination, Petitioner exhibited a significantly limited range of motion and was not able to walk on his heels or toes. Petitioner's gait was slow but normal. The sensory examination revealed decreased sensation in the left lateral leg more than the right. Reflexes were diminished but symmetric on both sides. PX 2 at 9-10.

Dr. Salehi testified he reviewed a lumbar spine MRI of January 21, 2015. He interpreted the images as showing a centrally herniated disc at L5-S1, compressing both traversing S1 nerve roots, with a possible extruded component of the herniation to the left, mild retrolisthesis of L5 over S1 and a centrally herniated disc at L4-L5 resulting in moderate bilateral lateral recess stenosis. PX 2 at 10.

Dr. Salehi testified he reached two diagnoses on February 6, 2015: lumbar degenerative disc disease and lumbar herniated disc. As for the former, the MRI showed degeneration of the L4-L5 and L5-S1 discs. PX 2 at 11. Lumbar disc degeneration, with or without herniation, can result in purely back pain. PX 2 at 11. Degenerative disc disease is often due to wear and tear, with or without trauma, but trauma can also be a competent cause of an annular tear, which could prompt disc disease to start forming. PX 2 at 12. Herniation of a disc through an annular tear can result in radicular pain. PX 2 at 12. It depends on the degree of nerve compression. PX 2 at 13. In Petitioner's case, it was the centrally herniated discs at both levels that caused pain in both legs. PX 2 at 13. Most disc herniations are off to one side but a centrally herniated disc can "catch both nerves." The central canal is very small. PX 2 at 14.

Dr. Salehi testified he initially recommended that Petitioner continue therapy and undergo a couple of injections. There was no "red flag" which prompted him to immediately recommend surgery and a lot of people improve with conservative care as time passes. PX 2 at 14. He restricted Petitioner to sedentary work with no lifting over ten pounds. PX 2 at 15. As of the first visit, he viewed Petitioner as potentially needing surgery, assuming the conservative route did not help. At the next visit, Petitioner reported no relief, despite having undergone therapy and two injections. Petitioner had started taking Opana, a very strong narcotic, due to back and leg pain. PX 2 at 15-16. Since Petitioner had not improved, he recommended a nerve decompression and two-level fusion. PX 2 at 16. The purpose of a fusion is to remove abnormal motion from discs. PX 2 at 18. Petitioner's radicular symptoms were more associated with the disc herniations than the disc degeneration. PX 2 at 17. He took Petitioner off work and directed him to return in four weeks if he had not yet secured authorization for the proposed surgery. PX 2 at 19. The surgery has not been authorized to date. Petitioner underwent an IME in May 2015 and remained symptomatic. At visits in May and June 2015, he continued to restrict Petitioner to sedentary work. He is still awaiting surgical authorization. PX 2 at 20.

Dr. Salehi testified that, from the beginning, Petitioner was candid with him about having had a prior back injury in 2011 for which he underwent treatment. As far as he knows, Petitioner was performing full duty up until the December 11, 2014 work accident. PX 2 at 21. Prior to that accident, Petitioner last underwent care in 2012, when he had injections. PX 2 at

21. He has seen no records indicating that Petitioner continued to actively treat between 2012 and the work accident. PX 2 at 21.

Dr. Salehi opined there is a causal connection between the work accident and Petitioner's current condition, "by way of aggravation of a pre-existing condition." PX 2 at 22. He bases this opinion on Petitioner's history that he had only minimal symptoms after undergoing injections in 2012 and experienced a dramatic increase in pain, requiring narcotic medication, after the work accident. PX 2 at 22. He further opined that, without surgery, Petitioner will remain in significant pain, needing narcotics, and will "really not be productive." PX 2 at 22. The surgery gives him a good chance of improving, although there is never a guarantee of success. PX 2 at 22-23. Since he has not seen the pre-accident MRI, he cannot comment on whether the accident caused a change in the size of the disc herniations. However, this is "not really" significant since a person can have pain stemming from an annular tear and loss of disc height without herniation. "The size of the herniation really doesn't matter." PX 2 at 24. The fusion part of the recommended surgery is intended to address the degenerative disc disease. PX 2 at 24. The hemilaminectomy is intended to relieve the leg pain. PX 2 at 25. The theory of aggravation is supported by the fact Petitioner began having leg pain after the accident. PX 2 at 25.

Dr. Salehi opined that, as of Petitioner's last visit, Petitioner was capable of performing sedentary duty. Sedentary duty is more or less equivalent to office work. PX 2 at 26.

Under cross-examination, Dr. Salehi testified that the restrictions he imposed as to lifting, pushing, pulling, bending and twisting point to a job within the sedentary framework. PX 2 at 27. He learned from reading Dr. Mather's report that Petitioner underwent an MRI in 2011. He learned of this MRI the morning of the deposition. PX 2 at 28. Petitioner clearly had significant enough symptoms in 2011 to warrant an MRI. PX 2 at 28. Petitioner's degenerative disc disease started before the work accident. Petitioner would have been fairly young as of 2011 so he does not know for how long he had degenerative disc disease. PX 2 at 29. A myelogram is an "old fashioned way of diagnosing." It is seldom used. PX 2 at 30. If a doctor is unsure whether an MRI shows a disc herniation, he could order a myelogram. PX 2 at 30.

Dr. Salehi testified he would not necessarily expect Petitioner's post-accident MRI to show acute findings. Since he has not seen any pre-accident MRI, he cannot say whether the post-accident MRI showed acute findings. He is aware that Dr. Mather saw both MRIs and opined that the second MRI showed improvement of the herniations. PX 2 at 31-32.

Dr. Salehi reiterated it is his assumption Petitioner performed full duty between 2012 and the December 11, 2014 accident. He did not ask Petitioner about his job history. Petitioner told him he is a general laborer. PX 2 at 33. It would be "new information" to him if he learned Petitioner did not work in 2012 or 2013 and started working for Respondent about a month before the accident. PX 2 at 34.

Dr. Salehi testified that Petitioner described tripping and "tweaking" his back but not falling. PX 2 at 33-34. He does not view a tripping/tweaking event as inherently innocuous. There are multiple studies showing that a degenerated disc "is more likely to take on an injury than a normal disc." PX 2 at 35, 37. A sudden movement could cause degenerated discs to become symptomatic. It is possible, however, that Petitioner could have aggravated his back by simply sneezing. PX 2 at 36. He cannot say that any kind of event, no matter how minor, could have caused Petitioner's symptoms. PX 2 at 37. The event Petitioner described on May 1, 2015, i.e., almost falling due to his leg giving out while he was trying to mow his lawn, could have caused back problems. PX 2 at 38. Petitioner was off work as of May 1, 2015 but that would not be inconsistent with his trying to mow his lawn, if he was using a small, self-propelled mower. PX 2 at 39-40. There would be no problem with Petitioner mowing his lawn in this fashion. PX 2 at 39-40. On June 26, 2015, Petitioner reported doing things he should not have been doing. He did not ask Petitioner what things he was doing. He does not know what Petitioner meant by that comment. PX 2 at 40. He has not recommended that Petitioner undergo flexion-extension X-rays. Such X-rays are ordered if spinal instability is suspected. PX 2 at 41. There are two kinds of instability. The first is the "gross" kind, for which you would order flexion-extension X-rays. With the second kind, you do not see gross instability. The pain is "due to micro motion" and flexion-extension X-rays would be a waste of time and money. PX 2 at 41-42. He did not prescribe Opana for Petitioner. He believes Dr. Xia prescribed this. PX 2 at 42. He last saw Petitioner in June 2015. He imposed work restrictions at that time. His opinion as to the need for these restrictions has not changed. PX 2 at 42.

On redirect, Dr. Salehi testified that Petitioner's subjective complaints correlate with his objective findings and test results. He has to rely on a patient's subjective complaints in order to make treatment related decisions. PX 2 at 44. Petitioner had significant complaints. He rated his pain at 8/10. A degenerated disc "is more likely to take on a new injury by way of loading, flexion, twisting, motions." PX 2 at 45. He does not have any information indicating Petitioner was injured due to sneezing or climbing stairs. The history he obtained was the history of the work accident. PX 2 at 44, 46. He knows of no back injuries between the 2011 injury and the December 11, 2014 injury. PX 2 at 46.

Under re-cross, Dr. Salehi testified he believes Petitioner was probably twisting when the accident occurred. PX 2 at 46. Petitioner was not lifting anything. PX 2 at 46-47.

Dr. Mather testified by way of evidence deposition on June 30, 2016. RX 1. Dr. Mather testified he graduated from the University of Illinois Medical School in 1985. During his post-graduate years, he underwent fellowship training in both arthritis and biomechanics and spine reconstruction. RX 1 at 4. Mather Dep Exh 1. He is board certified in orthopedic surgery and specializes in spine surgery. RX 1 at 4-5.

Dr. Mather testified he examined Petitioner on May 4, 2015 but did not independently recall the examination. RX 1 at 5-6. He relied on his May 4, 2015 report while testifying. RX 1 at 6.

Dr. Mather reviewed the history he obtained from Petitioner on May 4, 2015, noting that Petitioner reported taking Opana, as prescribed by Dr. Xia. Dr. Mather testified that, in his opinion, Opana is to be prescribed for chronic rather than acute pain management. RX 1 at 8. Opana is "very close to medical grade Heroin." The fact that Dr. Xia prescribed it leads him to believe Petitioner "had been on pain medication for a while." RX 1 at 8-9. Moreover, Petitioner reported taking Opana three times per day. Opana is intended to be taken once or, at most, twice a day. RX 1 at 9.

Dr. Mather noted that Petitioner exhibited markedly positive Waddell's findings with simulated axial rotation of the lumbar spine and axial compression. These findings "are a strong indicator" of functional overlay or functional pain. This "may be unconscious by the patient." RX 1 at 11. On vibratory testing, Petitioner indicated he could not feel any vibration in either leg. This "does not correlate with anything that [Petitioner] could have, because that's really a spinal cord reflex. It's not a nerve root compression sign." Moreover, Petitioner "had normal vibration sense in the upper extremities." RX 1 at 11. Petitioner had another "very unusual" test result in that he "had loss of sensation in all of the dermatomes of his right leg below the knee" but would sharply withdraw his foot with pinprick testing to the sole. Petitioner indicated he could feel the pinprick but could not tell whether it was sharp or dull. RX 1 at 12. These test results are "signs of non-organic complaints." Petitioner had normal reflexes at both knees, no reflex on the right ankle and one plus one on the left ankle. RX 1 at 12. Petitioner's absent right ankle reflex could stem from an old injury, an Achilles tendon tear, diabetes or alcohol usage. RX 1 at 13. Petitioner's seated and supine straight leg raising test results were inconsistent. RX 1 at 13. Straight leg raising caused only back pain. RX 1 at 14. If Petitioner had a disc herniation, he would have complained of leg pain. RX 1 at 14.

Dr. Mather testified he reviewed the pain diagram Petitioner completed along with Dr. Salehi's records. He stated: "obviously, Dr. Salehi did not do as extensive an exam as I did" but he noted "a lot of subjective complaints without objective findings."

Dr. Mather testified that, as of his May 4, 2015 examination, he felt the work accident could have caused the L5-S1 disc herniation shown on the January 21, 2015 MRI, which he personally reviewed. He also felt that the 2015 MRI should be compared with the previous 2011 MRI "to find out if this was a pre-existing herniation." RX 1 at 17. He believed the conservative treatment to date to be reasonable and necessary but felt Petitioner should undergo a CT myelogram before undergoing any surgery. A myelogram would show whether there was actual nerve root compression "because the herniation was fairly small." He saw no evidence that the herniation was compressing the left side yet Petitioner had left-sided symptoms. RX 1 at 18-19. A myelogram is similar to an epidural injection in that it involves a physician putting a needle into the lower back and injecting dye so that a radiologist can determine whether there is nerve compression. Following the myelogram, the patient undergoes a CT with the dye still in place. RX 1 at 19. This type of scan produces "better pictures." RX 1 at 19.

Dr. Mather testified he disagrees with Dr. Salehi's recommendation of a bilateral discectomy and fusion of L4-S1. He disagrees because there is no nerve root compression on either side and straight leg raising produced no complaints of leg pain. Additionally, he felt that Petitioner was a poor surgical candidate, based on the positive Waddell's findings. RX 1 at 20. If Petitioner had nerve root compression, he would have had exclusively right-sided symptoms, no loss of vibratory sensation and no loss of the ability to walk on his heels. If Petitioner had the CT myelogram and it showed nerve root compression, it would be appropriate for him to undergo a right L5-S1 discectomy. RX 1 at 20-21.

Dr. Mather testified that, as of May 4, 2015, he felt Petitioner should be restricted to lifting 10 pounds pending receipt and review of the prior MRI. RX 1 at 21. He authored an addendum on June 24, 2015, after reviewing that MRI. RX 1 at 21. Mather Dep Exh 3. The 2011 MRI showed very large herniations at both L4-L5 and L5-S1. The 2015 MRI showed marked improvement. The 2011 MRI report also showed that Petitioner had "longstanding back complaints." RX 1 at 22-23. After reviewing the 2011 MRI, he concluded that Petitioner had a pre-existing condition rather than a condition stemming from the work accident. RX 1 at 23. The 2015 MRI did show right-sided nerve root compression at S1, no compression on the left side and marked improvement of the two herniations shown on the earlier MRI. The L4-L5 level now just showed minor bulging and the L5-S1 herniation "was markedly smaller." RX 1 at 23. The 2015 MRI showed no acute findings. He would have expected to see such findings, based on the subjective complaints Petitioner voiced. RX 1 at 25. The accident Petitioner described, i.e., "just stepping off a box," was "very minor" and the whole thing "just sounds a little fishy," given that Petitioner worked for Respondent for only a month. RX 1 at 26. Although Petitioner had right-sided nerve root compression, he did not believe he was a suitable candidate for surgery, based on his positive Waddell's findings. RX 1 at 24. He believed Petitioner was capable of full duty and did not require more care. RX 1 at 24.

Under cross-examination, Dr. Mather testified that, prior to the May 4, 2015 examination, Petitioner had undergone physical therapy and two injections. RX 1 at 29. He agreed that both the 2011 and the 2015 MRIs showed disc herniations at L4-L5 and L5-S1, although the 2015 herniations were "markedly improved." RX 1 at 29-30. Regardless of causation, Petitioner, at this point, requires no more care. If he only was aware of the two MRIs and complaints of low back pain and bilateral leg pain, he would recommend therapy, up to ten visits. RX 1 at 31. Petitioner "really did not meet the criteria for injections because he didn't have validated radiculopathy." RX 1 at 32. If an MRI showed a centrally located herniation at L4-L5, that herniation could possibly cause bilateral leg pain but that would be "atypical." RX 1 at 33.

Dr. Mather conceded that the two MRIs showed significant right-sided nerve compression at S1 and that, in his original May 4, 2015 report, he stated Petitioner might need a microdiscectomy at L5-S1 if the MRIs showed this. He later changed his mind about Petitioner needing surgery because Petitioner had "no recreation of leg pain with straight leg raising." He should have made this point clear in his May 4, 2015 report. RX 1 at 34-35. No doctor who has evaluated Petitioner has reproduced leg pain with straight leg raising. He is

now focusing on the straight leg raising results because "about 50% of people in [Petitioner's] age group will have asymptomatic disc herniations." If he can get a patient to 80 or 90 degrees with no leg pain, he knows the disc herniation is asymptomatic. RX 1 at 36. He does not view the January 2015 MRI as showing a centrally herniated disc at L4-L5. It just shows a "minor bulge" at L4-L5. The bulge is central. A central bulge can cause bilateral leg pain but only in patients with stenosis. If a patient reports new pain after an accident, that could be considered an aggravation of a pre-existing condition "but the question is: is this psychogenic pain or real pain?" Petitioner "had so many non-organic findings" on examination that he views Petitioner's pain as non-organic. RX 1 at 39-40.

Dr. Mather testified it appears Petitioner concluded his previous treatment in 2012. He has seen no records indicating Petitioner continued undergoing active back care between 2011 and 2014. RX 1 at 40. He has seen no records indicating Petitioner had leg pain before the work accident. RX 1 at 41. Nor has he seen any records showing that Petitioner was taking pain medication before the accident. RX 1 at 41. Petitioner told him he was taking Opana but that usage should have been registered with the State, which it wasn't. RX 1 at 42. Opana would help someone who had acute back pain. RX 1 at 43. He has no evidence indicating Petitioner was unable to perform full duty for Respondent between his hire date of November 19, 2014 and the accident of December 11, 2014. RX 1 at 45. Hypothetically, a patient who has pre-existing disc disease is not more susceptible to further spine injury. RX 1 at 44. An aggravation could, hypothetically, result from the kind of tripping incident Petitioner described. RX 1 at 44. It "sounds kind of fishy" but it could happen objectively. RX 1 at 44. To his knowledge, no one recommended that Petitioner undergo back surgery before the work accident. RX 1 at 45. The "missing link" in Petitioner's case is "what is causing his left leg pain." Hypothetically, a central bulge can cause bilateral leg pain but Petitioner has negative straight leg raising. RX 1 at 45. A fusion can be used to treat mechanical back pain but it is "not a standard treatment." RX 1 at 45-46. It is also used to treat degenerative disc disease but it is not covered by certain major carriers, including Aetna and Blue Cross. RX 1 at 46. If Petitioner were to have a fusion, it would not relieve his back pain. Petitioner's multiple positive Waddell's signs "correlate with a poor outcome" plus Petitioner "has no findings of left leg compression." RX 1 at 46-47.

Dr. Mather testified that, of the patients he treats, about 10 or 15 percent are workers' compensation patients. He devotes 5 to 7 percent of his practice to conducting independent medical examinations. Of these examinations, "almost all" are for the respondent, due to the "very nature of the business." Petitioner's attorneys are "far too smart to pay for an IME." RX 1 at 48.

On redirect, Dr. Mather testified he "ran out of Waddell's tests to try on" Petitioner. Petitioner "registered positive on all of them." RX 1 at 49. Petitioner's subjective complaints are not supported by objective findings. RX 1 at 49.

Under re-cross, Dr. Mather reiterated that, hypothetically, it is possible for a patient with herniations at L4-L5 and L5-S1 to have subjective complaints of low back and bilateral leg pain. RX 1 at 49-50.

Petitioner testified he would rate his current pain level at 6 to 7 on a scale of 1 to 10. The intensity of his pain varies, depending on his activity level. He is currently taking Norco, as prescribed by Dr. Connolly, his family physician. Before the December 2011 accident, his low back pain was right-sided. It is now in the left side of his back. He is using a cane, as prescribed by Dr. Connolly, but not because of his back condition. Dr. Connolly recommended he use the cane because he has diabetes and associated neuropathy in his feet. He had three injections but they did not help at all. Physical therapy also did not help.

Petitioner testified he trusts Dr. Salehi and will seek the surgery Dr. Salehi has recommended if the Arbitrator awards it.

Under cross-examination, Petitioner testified his accident occurred at approximately 9:30 AM, his usual break time. He was not allowed to smoke in the break room. He typically went outside to smoke after eating something in the break room. It was dusty in his work environment. When he went to step over the cord connector, his foot slipped off the connector, causing him to twist his back. He did not fall. He managed to catch himself. As of the accident, he had not been diagnosed with diabetes and was not having any foot problems. When he applied to work for Respondent, he did not advise Respondent of his prior back problems. Respondent did not ask him about this. He took Opana at Dr. Xia's recommendation but cannot recall exactly when he first took this medication. He cannot recall whether he advised Dr. Salehi of his prior low back treatment. He believes Dr. Salehi reviewed his pre-accident lumbar spine MRI. He did not previously know that Dr. Salehi testified [at his deposition] that he did not review this MRI. The MRI he underwent before the accident was performed on June 4, 2011. He underwent injections in 2011. A pain medicine specialist at St. Joseph's administered these injections. He does not recall seeing Dr. Michalow, an orthopedic surgeon, at that time. He has no recollection of injuring his lower back in a tree-related incident when he was 18 years old. He does not recall giving a statement to an adjuster from Gallagher Bassett on December 24, 2014. He recalls discussing only the post-accident MRI with Dr. Salehi. He does not recall anyone suggesting he undergo back surgery before the work accident. He underwent treatment by Dr. Syed at Liberty Medical Center between May 2011 and July 2013. Dr. Syed was his family physician at that time. He now sees Dr. Connolly. He has health coverage through Medicaid but has not discussed using Medicaid with Dr. Salehi, insofar as coverage for the recommended surgery goes.

On redirect, Petitioner denied undergoing treatment with Dr. Xia before the December 11, 2014 work accident. He had an accident in 2011 and recalls undergoing back injections in February 2012. He gets confused, date-wise, due to his diabetes-related medication. He believes Dr. Salehi saw his pre-accident MRI but he is not sure about this. He knows Dr. Salehi saw his post-accident MRI. He is now 37 years old. He cannot recall everything that happened to him 19 years ago, when he was 18.

Under re-cross, Petitioner testified he has no recollection of receiving or using a TENS unit or massage device for back pain in 2011.

In addition to the exhibits previously described, Petitioner offered into evidence a group of bills from Integrated Pain Management, ATI, Neurological Surgery and MedWorks. Only the bill from Integrated Pain Management shows an outstanding balance. The balance is $419.00. PX 1.

Arbitrator's Credibility Assessment

Petitioner was a poor historian insofar as his past medical history was concerned. He did not recall injuring his back as a teenager, although he reported this to several physicians. He did, however, readily acknowledge injuring his back in 2011. He did not recall experiencing leg pain after this injury but his records document radicular complaints.

Respondent's examiner, Dr. Mather, noted significant symptom magnification. Petitioner's treating physicians, including several associated with MedWorks, the company clinic, did not. Dr. Mather questioned whether it was appropriate for Petitioner to be taking Opana ER. At his deposition, he testified Petitioner was exceeding the typical dosage for this medication. Dr. Xia started Petitioner on Opana ER on March 13, 2015 but his subsequent notes of April 24, 2015 and June 5, 2015 reflect that Petitioner reported taking himself off this medication due to side effects. At the hearing, Petitioner testified to taking Norco for pain control.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed work accident of December 11, 2014 and his current lumbar spine condition of ill-being?

There is no dispute as to accident. Arb Exh 1. The question for the Arbitrator to resolve is whether the accident aggravated Petitioner's pre-existing lumbar spine condition of ill-being.

Respondent maintains the accident was innocuous and did not result in any worsening of that pre-existing condition. The Arbitrator does not view the accident as innocuous. Petitioner testified that his foot slipped after he stepped onto an electrical cord cover, causing him to lose his footing and twist his lower back in an effort to avoid falling. A physician at the company clinic described Petitioner as injuring his back when his foot slipped off of a "walkover." Respondent's examiner, Dr. Mather, clarifed that the electrical box Petitioner stepped onto was not at or near ground level. Rather, it was a foot tall. He acknowledged that this incident could have caused the disc herniation he saw on Petitioner's 2015 MRI. Mather Dep Exh 2.

Respondent also relies on the 2011 and 2012 treatment records in arguing that the accident did not result in an aggravation. The Arbitrator has examined those records in detail. At the outset, the Arbitrator notes that the 2011 incident was not limited to Petitioner's lumbar spine. The records document neck as well as back complaints. While the records show high

pain ratings and reflect Petitioner, as a layperson, felt he needed surgery, there is no evidence indicating any physician recommended surgery in 2011 or 2012. Nor is there evidence indicating that Petitioner continued to pursue treatment after August 2012, when a physician recommended he undergo injections. Finally, the Arbitrator notes there is no dispute that Petitioner successfully performed a factory line job for Respondent for about a month before the December 11, 2014 accident.

Insofar as causation is concerned, the Arbitrator finds Dr. Salehi more persuasive than Dr. Mather. Dr. Mather described the undisputed accident as "very minor" yet his own initial history reflects Petitioner's foot slipped after he stepped onto an electrical box that was a foot tall. Mather Dep Exh 2. Dr. Mather lost credibility when he attempted to distance himself from opinions he had previously voiced. For example, Dr. Mather stated in his initial report (Mather Dep Exh 2) that Petitioner might be a surgical candidate based on the 2015 MRI if a myelogram showed right nerve root compression. When he acknowledged, under cross-examination, that both the 2011 and 2015 MRIs showed this compression, he changed his reasoning and opined that surgery would be inappropriate based on the straight leg raising test results. In his initial report, he asserted that a paracentral herniation should not cause bilateral leg complaints but, under cross-examination, he admitted it could. RX 1 at 45, 49. While Dr. Salehi did not review the 2011 MRI, he opined that the size of a disc herniation "really does not matter," noting that symptoms can be caused even by annular tears that result in loss of disc height. Dr. Mather did not persuasively counter this opinion. Dr. Salehi also persuasively explained that a degenerated disc more readily responds to a sudden movement, "taking on" an injury.

The Arbitrator views Petitioner's current lumbar spine condition as multi-factorial. The pre- and post-accident records prompt the Arbitrator to conclude that the 2011 incident, the 2014 accident and post-accident flare-ups resulting from Petitioner's attempt to perform work or charitable services outside his restrictions played roles in that condition. Under Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2001), an employer takes an employee as it finds him. The employee need only establish that a work accident was a cause of his condition. He is not required to eliminate all other possible causes.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims outstanding charges from Integrated Pain Management. PX 2. The bill from this provider shows charges totaling $4,678.00, Gallagher Bassett payments totaling $2,000.39, write-offs totaling $2,258.61 and a balance of $419.00. Neither side offered fee schedule evidence so it is unclear to the Arbitrator whether the $419.00 represents balance billing. The Arbitrator finds the treatment rendered by Integrated Pain Management to be causally related as well as reasonable and necessary. The Arbitrator awards the outstanding charges of $419.00 to the extent these charges do not represent improper balance billing.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from January 20, 2015 through the hearing of October 19, 2016. Respondent stipulated Petitioner was temporarily totally disabled from January 20, 2015 through July 14, 2015. Arb Exh 1. The Arbitrator views this stipulation as at least potentially inconsistent with Respondent's causation defense. [See Hector Fontalvo v. Food Team, Inc., 2014 Ill Work Comp LEXIS 536, in which the Commission (Basurto, Gore and Latz), in a decision on a second Circuit Court remand, emphasized the binding nature of stipulations, citing Walker v. Industrial Commission, 345 Ill.App.3d 1084 (4th Dist. 2004), while simultaneously acknowledging that the payment of benefits is not an admission of liability.]

The Arbitrator has previously found in Petitioner's favor on the issue of causal connection. The Arbitrator did not base this finding on Respondent's stipulation to a period of temporary total disability. The Arbitrator views Petitioner's causally related lumbar spine condition as unstable since March 20, 2015, when Dr. Salehi recommended surgery. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). The Arbitrator also notes that, while Respondent initially offered accommodated duty, for a period of about a week following the undisputed accident, there is no evidence it renewed that offer after Dr. Salehi imposed various restrictions in June 2015.

Is Petitioner entitled to prospective care?

Petitioner seeks prospective care in the form of the surgery Dr. Salehi previously recommended. The Arbitrator notes that, as of the hearing, the doctor had not seen Petitioner for over a year. The Arbitrator, having previously found in Petitioner's favor on the issue of causation, awards prospective care in the form of a return visit to Dr. Salehi, along with the previously recommended surgery, assuming the doctor still finds this surgery to be appropriate.

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

MADONNA HAYNES,

Petitioner,

vs.

NO: 14 WC 11702

FAIR HAVEN CHRISTIAN HOME,

18IWCC0142

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, medical expenses, and 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.

On the issue of medical expenses, we find that Petitioner failed to prove that some of the bills in Px10 were causally related to her injury and find that some are duplicative. Following is our analysis of the medical bills (listed in the order they appear in Px10):

Date	Description of Bill and Commission Finding	Amount Claimed	Amount Awarded
1/29/15	Collection Notice (Taylorville Memorial Hosp.) Finding: There is no detailed billing included. This appears to be a collection notice for charges that are accounted for elsewhere. This is denied.	$1,249.80	0
3/4/15	Collection Notice (Clinical Radiologists) Finding: Although there is no itemized billing for this, we find that this is reasonable, necessary, and related to the x-rays that Petitioner had taken at the Emergency	343.00	343.00

	Room on 12/19/13.		
1/27/15	Taylorville Memorial Hosp. letter indicating a balance due for a "Discharged" date of 6/7/14 Finding: This seems to be related to Petitioner's 6/7/14 ER visit and there are records in evidence to support this. However, this appears to be duplicative of the itemized charges for the 6/7/14 Taylorville Hosp. visit that are listed below. This amount is denied.	401.09	0
3/6/14	Taylorville Memorial Hosp. charges for ER visit Finding: There are no records in evidence to support this visit and Petitioner never testified about it. These charges are denied.	559.00	0
4/15/14 4/18/14 4/21/14	Taylorville Memorial Physical Therapy visits Finding: These are supported by the records and are awarded.	657.00	657.00
6/7/14	Taylorville Memorial ER Finding: These are supported by the records and are awarded.	555.00	555.00
12/19/13	Decatur Memorial ER (on date of accident) Finding: There are multiple billing statements related to these same charges. We find that the itemized bill is supported by the records and is awarded.	1,640.51	1,640.51
4/4/14 4/11/14 4/25/14	Springfield Clinic Finding: These are supported by the records and are awarded.	380.00	380.00

Px10 contains a "Statement of Professional Services" from the Springfield Clinic bill, dated October 22, 2015, reflecting charges from January 15, 2015 to September 3, 2015. We find that the only charges that are causally related, reasonable, necessary, and supported by the medical records are:

9/3/15	Dr. Schopp (surgery charges)	6,377.00	6,377.00
9/3/15	Dr. Schopp (surgery charges)	1,594.25	1,594.25

Other charges are listed for Dr. Schopp and Dr. Pittman but there are no supporting records in evidence. Since we are unable to determine whether they are causally related, these are denied:

6/23/15	Dr. Schopp	$115.00
4/28/15	Dr. Schopp	319.40
8/26/15	Dr. Pittman	335.00

The remaining charges contained in this bill appear to be for unrelated services and are denied. Examples of these charges include:

1/15/15	Sally Vespa PA	$71.67

1/21/15	Hemorrhoidectomy	201.87
7/2/15	Sally Vespa PA	145.00
7/23/15	Dr. Pittman ("Destr Ben Les/Warts 1-14")	570.00
7/23/15	Urinalysis	81.00

There is another "Statement of Professional Services" from Springfield Clinic, dated December 8, 2015, which reflects an "Amount Due" of zero and "charges pending" with insurance of $175.00. There was no itemized billing attached so it is impossible to know what these pending charges are. This is denied.

Based on the above, we find that Petitioner has proven that medical expenses totaling $11,546.76 are reasonable, necessary and causally related. Respondent shall pay these expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

The Commission also modifies the decision to correct a couple of errors. First, the Arbitrator found that Petitioner's "complaints were consistent throughout each visit with right shoulder pain (and initially right elbow pain). Only after the December 19, 2013 incident is there any record noting limited range of motion in the shoulder which was only corrected by surgical intervention." Dec. at 7 (unnumbered). We find that Petitioner's complaints were not entirely consistent because, on January 17, 2014, she returned to Dr. Chen for right elbow complaints and there was no mention of the right shoulder. We also find that the December 2, 2013 record of Dr. Chen, which pre-dated Petitioner's accident, noted right shoulder pan with abduction and adduction at that time. Despite these errors, we still find the causation opinion of Dr. Schopp to be more persuasive than that of Dr. Hauter who is a no-longer-board-certified internal medicine doctor and not an orthopedic surgeon.

We also correct an error in the Arbitrator's analysis of permanency factor (v) under §8.1b. The Arbitrator wrote, "She has had **three injections post surgery** and currently takes Aleve." Dec. at 6 (Numbered but incorrectly, Emphasis added.) Petitioner testified that she underwent two injections prior to her surgery and one injection afterwards. T.18. Petitioner was released by Dr. Schopp on December 8, 2015. He noted that Petitioner had complete range of motion but still some weakness. There are no medical records in evidence to support any post-surgery injections but Petitioner testified that one was performed on March 2, 2016. T.17. We modify the decision to correct the number of injections Petitioner received and when. However, despite this error, we affirm the Arbitrator's overall permanency analysis and the award of 10% of the person as a whole under §8(d)2.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $305.33 per week for a period of 82.6 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

18IWCC0142

the sum of $274.80 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 use of 10% of the Petitioner as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $11,546.76 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,700.00. 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: MAR 12 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 1/31/18
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAYNES, MADONNA
Employee/Petitioner

Case# **14WC011702**

FAIR HAVEN CHRISTIAN HOME
Employer/Respondent

18IWCC0142

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:

4535 DENNIS R ATTEBERRY
220 W MAIN CROSS
TAYLORVILLE, IL 62568

2904 HENNESSY & ROACH PC
STEPHEN KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

18IWCC0142

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

Madonna Haynes
Employee/Petitioner

v.

Fair Haven Christian Home
Employer/Respondent

Case # 14 WC 11702

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 23, 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 _____

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FINDINGS

On **12/19/13**, 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 **$23,816.00**; the average weekly wage was **$458.00**.

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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** in non-occupational indemnity disability benefits, for a total credit of **$0**.

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

ORDER

Respondent shall pay Petitioner temporary partial disability benefits of $305.33/week for 82.6 weeks, commencing April 9, 2014 through November 10, 2015, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services of $14,119.96 as provided in Section 8(a) of the Act pursuant to the medical fee schedule.

The Respondent shall pay the Petitioner the sum of $274.80 per week for a period of 50 weeks as provided in section 8(e) of the Act, because the injuries sustained caused 10% loss to 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

9/10/16
Date

SEP 20 2016

Madonna Haynes
v.
Fair Haven Christian Home

FINDINGS OF FACT and CONCLUSIONS OF LAW

At the time of arbitration, the issues included (a) whether the Petitioner's current condition of ill-being was related to the accident on December 19, 2013; (b) whether the Respondent has paid all reasonable and necessary medical expenses; (c) whether the Respondent has paid all reasonable TTD; and (d) nature and extent of the Petitioner's injuries from the December 19, 2013 accident.

The Arbitrator finds:

Petitioner testified that she worked for Respondent as a certified nurse's assistant (CNA) since 2011. Petitioner further testified that she commuted to work with co-workers Kimberly Pitti and Denise Bernardini. December 19, 2013, the weather was both icy and snowy. Petitioner testified Kimberly Pitti drove her vehicle and parked in an area of the parking lot that was designated for employee parking. Petitioner testified Ms. Pitti exited the vehicle first then Ms. Bernardini then her. Petitioner testified that both women had told Petitioner to be careful because of ice, and as soon as that was said, Petitioner slipped and fell landing on her right shoulder and back. Petitioner testified that she was in immediate pain. She also testified that prior to the fall her right shoulder was not hurting.

Kimberly Pitti testified that she drove on December 19, 2013 and parked in the designated employee parking lot. When they arrived she got out first. She slipped on the parking lot but didn't fall. She yelled back to Madonna that she needed to be careful because there was black ice. However, when she looked back, she noticed that Madonna Haynes had already fallen and was laying on her right side. She was crying and yelling "my arm".

Denise Bernardini testified that she was a passenger in the car and that she got out second. She testified that Ms. Pitti first slipped, then she slipped and both told Madonna Haynes to be careful but it was too late. She had already fallen. While it was dark, she was able to see that Madonna had landed on her right side. She testified that Madonna Haynes was screaming, yelling and crying about her right arm.

Admitted into evidence as Respondent's exhibit 2 was a report from Dr. Chen dated December 2, 2013, wherein the Petitioner was seen by Dr. Chen complaining of pain in her neck and her right arm.

Petitioner testified that her shoulder was not hurting her on the date in questions or the days leading up to the accident after her initial complaint on December 2, 2013. Kimberly Pitti stated that prior to December 19, 2013, she road to work with Madonna Haynes daily and while she repeated complained about her feet she had not complained about her shoulder or arm.

Denise Bernardini testified that she road with Kimberly Pitti daily and that prior to December 19, 2013, Madonna Haynes would complain about her foot but has never complained about her shoulder and arm. After December 19, 2013, both Kimberly Pitti and Denise Bernardini stated that she complained about her shoulder and arm daily.

Respondent called Angie Herst to testify. She testified on cross-examination that she regularly worked with the Petitioner before December 19, 2013 and had never heard the Petitioner complain about her shoulder but that she had heard her complain of her shoulder after the fall on December 19, 2013 while she was working light duty. She also testified that on December 19, 2013, she went outside to where Mrs. Haynes was laying on the ground. She heard her complaining about her shoulder. She helped her get into a wheel chair and get her inside. She then had someone driver Madonna Haynes to the emergency room.

Petitioner testified that she was taken to Decatur Memorial Hospital. Decatur Memorial Hospital records were admitted into evidence as Petitioner's exhibit 1. Petitioner presented to E.R. with complaints of right shoulder and elbow pain after falling on ice. The notes indicated that her pain was continuous, moderate and sharp. It was worse with movement. She received x-rays to her shoulder and elbow however, the notes indicated that this was difficult given the pain the Petitioner was in. X-rays did not reveal any fractures. She was diagnosed with a right shoulder strain. (Pet. Ex. 1).

Petitioner followed back up with her primary care physician, Dr. Hwa Long Chen at the Christian County Medical Clinic on January 17, 2014. A copy of Dr. Chen's records were admitted into evidence as Petitioner's exhibit 2). The Petitioner presented with complaints of the right arm stemming from a work related incident. After examination, Petitioner was diagnosed with a sprain of the elbow and forearm. (Pet. Ex. 2)

She followed back up on February 19, 2014. History notes that she was still having shoulder and arm pain after a fall. She had been taking pain medication but at night she was in so much pain that she was unable to sleep. Dr. Chen noted that the Petitioner was unable to lift the arm more than 90 degrees without causing a lot of pain. Dr. Chen increased the pain medication dosage and for her to continue with physical therapy. Diagnosis was strain of the right shoulder. (Pet. Ex. 2).

Petitioner followed back up on March 26, 2014 with Dr. Chen. History notes that this was from a fall at work in December 2013. Petitioner's right arm and shoulder were still very painful. She was still having difficulty raising her arm. (Pet. Ex. 2)

Petitioner was referred to Dr. Jeffrey Schopp at Springfield Clinic. Dr. Schopp is a board certified in general orthopedic surgery. The Springfield Clinic Records and Dr. Schopp's deposition was admitted into evidence as Petitioner's exhibit 3 and 4 respectively. Petitioner first seen Dr. Schopp's office on April 4, 2014. The history provides right shoulder pain after falling on ice walking into work on December 19, 2013 and landing directly on her right shoulder.

History notes that she cannot move the arm without pain. On examination, the Petitioner had limited range of motion of 10 to 15 degrees to internal rotation. Normal being 90. She had weakness in the muscles of the rotator cuff of a 3/5. Assessment was a right shoulder injury with likely rotator cuff tear. She was placed on work restrictions of no lifting greater than 20 pounds. (Pet. Ex. 3 and Pet. Ex. 4, pg. 6)

Dr. Schopp ordered an MRI. The MRI was performed on July 22, 2014. The MRI was admitted into evidence as Pet. exhibit 5. The MRI findings were supraspinatus moderate tendinosis and acromiclavicular arthritis. Dr. Schopp opined that his interpretation was mild arthritis with severe shoulder tendinitis. Dr. Schopp opined that falls such as described in the history can aggravate those conditions. (Pet. Ex. 4 , pg. 9).

Petitioner followed back up with Dr. Schopp on August 26, 2014. Dr. Schopp testified that she was doing better with physical therapy but she still had limited range of motion. The Petitioner was given a corticosteroid injection in the shoulder to address the tendinitis. Mrs. Haynes followed back up with Dr. Schopp on October 14, 2014. The injection had not helped. On October 14, 2014, Dr. Schopp's notes on October 14, 2014 refer to significant injury to the anterior supraspinatus and also referred to a full thickness tear. Dr. Schopp opined that this was not degenerative and that a full thickness tear term can be used interchangeably with severe tendinosis. (Pet. Ex. 3 and Pet. Ex. 4, pg. 12).

Petitioner seen Dr. Schopp on November 25, 2014. Petitioner was continued to be diagnosed as having right shoulder impingement with acromiclavicular joint arthroscapthy. At this time, a right shoulder arthroscopy was recommended. (Pet. Ex. 3 and Pet. Ex 4 pgs. 13-14.) A discussion was also had on November 25, 2014, wherein Dr. Schopp's records note that the shoulder pain occurring after the fall was an aggravation of a pre-existing condition. Dr. Schopp testified that he concurred with this causative opinion. (Pet. Ex. 4, pg. 14-15). Further Dr. Schopp opined that the fall of December 19, 2013 is a causative factor in the need for her to have surgery. (Pet. Ex. 4 pg. 24).

The Petitioner had surgery on September 3, 2015. The surgery involved an arthroscopic subacromial decompression, distal clavicle excision, and a rotator cuff repair. (Pet. Ex. 8).

Petitioner followed back up with Dr. Schopp on November 10, 2015. Petitioner was doing better with surgery. Petitioner's range of motion has improved. (Pet. Ex. 3). On December 8, 2015, the Petitioner followed back up with Dr. Schopp. she was doing well. She continued to have weakness in the supra and infraspinatus area. She was released from Dr. Schopp on this date.

Petitioner testified that the surgery helped. She still has pain with certain activity. This would include picking up milk, running a sweeper, mopping, folding laundry and over the head activities. She takes Aleve for the pain up to twice per day. She has had to return for a total of

three shots after surgery. She stated the shots help. She stated that she is currently on social security disability but has stated she is willing to try to go back to her old job if offered.

Tammy Wright was called by the Respondent to testify. She is the human resource manager for the Respondent. She stated that she has only worked for the Respondent for about one year. She was not present when the Petitioner worked for the Respondent. She testified that it is company policy not to allow light duty for employees unless it is for a work related injury. She indicated that the Respondent would not accommodate the light duty restriction placed on the Petitioner on April 4, 2014 by Dr. Schopp because they believed it was not work related.

The Petitioner was also seen by a Section 12 examiner, Dr Hauter, on January 28, 2015. Petitioner testified that she was only at the examination location for 15 minutes and only five minutes with Dr. Dru Hauter.

Dr. Hauter testified pursuant to an evidence deposition on January 28, 2015. (Resp. Ex. 1). Dr. Hauter testified that 99% of his practice is treating patients or dealing with occupational medicine, employees for pre-employment or injuries. He further opined that 90% of his IME practice is for the employer. (Resp. Ex. 1, pg. 5). Dr. Hauter opined that the Petitioner had a contusion and sprain to the right shoulder as the result of the fall on December 19, 2013. (Resp. Ex. 1 pg. 9). He opined that the impingement was not related to the fall and that she was at MMI as of January 17, 2014. (Resp. Ex. 1 pgs. 9-10). On cross-examination, Dr. Hauter admitted that he is currently not board certified. He further admitted that he only treats patients up to the point of needing a specialist intervention. (Resp. Ex. 1 pg. 15). Dr. Hauter also admitted on cross-examination that a person can have degenerative changes to a shoulder and be asymptomatic. He further conceded that a trauma can aggravate a pre-existing condition such as what was in the Petitioner's shoulder. (Resp. Ex. 1, pg. 20). Dr. Hauter did agree with Dr. Schopp's placing the Petitioner on work restrictions on April 4, 2014. While his recommendation may have been slightly different, it was still reasonable for impingement syndrome. (Resp. Ex. 1 pg. 25).

The Arbitrator Concludes:

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

Petitioner's current condition of ill-being in her right arm and shoulder is causally connected to her undisputed accident of December 19, 2013. While there was a December 2, 2013 office note from Dr. Chen indicating that she had complaints of pain in her shoulder on that date, Petitioner denied having pain after that date and the days leading up to December 19, 2013 as well as December 19, 2013 immediately prior to the accident. Petitioner testified that she landed on her right side and that she had immediate pain in her right arm and shoulder. This was confirmed by two co-workers, Kimberly Pitti and Denise Bernardini who testified that she road to work with the Petitioner on a regular basis. Prior to December 19, 2013, Petitioner complained about pain in her foot but never about pain in her shoulder. On December 19, 2013, both Ms. Pitti and Ms. Bernardini testified that the Petitioner had landed on her right side and that the Petitioner was screaming, crying and complaining about pain in her right arm.

Respondent's own witness, Angie Herst also testified that prior to December 19, 2013 she had never heard of the Petitioner complaining of her shoulder but she had heard her complaints immediately after the accidents as well as when she worked with her after the accident.

Dr. Schopp testified that he believed the shoulder pain that occurred after the fall was an aggravation of a pre-existing condition. (Pet. Ex. 4, pg. 14-15). Further Dr. Schopp opined that the fall of December 19, 2013 is a causative factor in the need for her to have surgery. (Pet. Ex. 4 pg. 24). Dr. Hauter's, the Section 12 examiner also concurred that there was an injury to the shoulder but that he believed it was only a strain that resolved by January 17, 2014. Dr. Schopp's testimony is given greater weight as the treating physician who is board certified as an orthopedic surgeon. Dr. Hauter admitted that he is no longer board certified and only treats patients until such time as they need a specialist like Dr. Schopp then, he refers the patients to specialist for treatment.

The medical records of Dr. Schopp also support the finding that the Petitioner's current condition of ill-being is related to the fall on December 19, 2013. Petitioner's complaints were consistent throughout each visit with right shoulder pain (and initially right elbow pain). Only after the December 19, 2013 incident is there any record noting limited range of motion in the shoulder which was only corrected by surgical intervention.

While the Petitioner did have a pre-existing condition, an employer takes an employee as they find her. An aggravation of a pre-existing condition is compensable. Based upon the evidence presented above, the Arbitrator finds that the Petitioner has met her burden by the preponderance of the evidence that her condition of ill-being is related to the December 19, 2013 fall at work.

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

The evidence by both Dr. Schopp and Dr. Hauter is that the treatment is fair and reasonable. Only issue is whether her current condition of ill-being is related to an accident that arose out of and in the course of the Petitioner's employment. Having found that the Petitioner's current condition of ill-being is related to the December 19, 2013 accident, the Arbitrator finds that the Respondent has failed to pay all appropriate charges for all reasonable and necessary medical services.

The medical bills were presented in Petitioner's exhibit 10.

Provider	Dates of Service	Amount
Taylorville Memorial Hospital		$1,249.80
Taylorville Memorial Hospital	3/6/14	$559.00
	4/15/14 to 4/21/14	$657.00
	6/7/14	$550.00
Decatur Memorial Hospital	12/19/14	$1,640.51
Springfield Clinic	4/4/14 to 4/25/14	$380.00
	1/15/15 to 9/3/15	$8740.65
Clinical Radiologist		$343.00

Respondent is to pay all related medical bills including those listed above in the amount of $14,119.96 pursuant to the fee schedule.

Issue (K): What temporary benefits are in dispute (TTD)

Petitioner is seeking TTD benefits from 4/9/2014 to November 10, 2015 for time she was on light duty and the Respondent refused to honor the light duty restrictions. Both Dr. Schopp and the Section 12 examiner, Dr. Hauter, testified that it was reasonable to place the Petitioner on light duty restrictions starting on April 9, 2014. Tammy Wright, the human resource manager for the Respondent, testified that it is company policy not to allow light duty for employees unless it is for a work related injury. She indicated that the Respondent would not accommodate the light duty restriction placed on the Petitioner on April 4, 2014 by Dr. Schopp because they believed it was not work related.

Based upon the Respondent's policy, they admitted that they did not accommodate the light duty because they were under the believe the restrictions were for a non-work related event. Since the Arbitrator has found that the Petitioner's current condition of ill-being is related to the work accident of December 19, 2013, the restrictions would be related to the work accident.

Respondent is to pay TTD benefits to the Petitioner for April 9, 2014 through November 10, 2015 at the rate of 305.33 for 82.6 weeks.

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

With regard to subsection (i) of Section 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 Section 8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a certified nursing assistant at the time of the accident. This is a strenuous job and an injury sush as Petitioner's makes it more difficult. The Arbitrator, therefore gives significant weight to this factor.

With regard to subsection (iii) of Section 8.1b(b), the Arbitrator notes that Petitioner was 58 years old at the time of the accident. Because Petitioner has less time to live with the results of the work accident than a younger person does, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earning capacity, the Arbitrator finds there was no evidence submitted regarding this factor. The Arbitrator, therefore gives no weight to this factor.

With regard to subsection (v), evidence of disability corroborated by the medical records. The records indicate initial injuries to right shoulder and elbo. The Petitioner has undergone surgical repair of the rotator cuff, a subacromial decompression, and a distal clavical excision. She has had three injections post surgery and currently takes Aleve. The Arbitrator gives great 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 10% loss of a person-as-a-whole pursuant to Section 8(d)(2) 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€18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Duane Rakestraw,
Petitioner,

vs.

NO: 14WC 43598

Standard Forwarding Company.,
Respondent,

18IWCC0143

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, 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 September 26, 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,000.00. 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: MAR 12 2018

Joshua D. Luskin

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CJD/rlc
049

L. Elizabeth Coppoletti

18IWCC0143

DISSENT

I must respectfully dissent. The majority agrees with the Arbitrator who found that Petitioner sustained an accidental injury to his left knee on November 17, 2014, when he slipped on ice while getting out of a truck, but denied causal connection after January 8, 2015 based on his pre-existing osteoarthritis. The Arbitrator found the opinion of Respondent's Section 12 examiner, Dr. Kolb, to be more persuasive than that of Petitioner's treating physician, Dr. Stewart, and found that the work accident caused only a "temporary aggravation of his severe osteoarthritis that had resolved by 1/8/15." *Dec. at 13.*

The relevant questions in this case are: 1) whether Petitioner's preexisting osteoarthritis was symptomatic prior to his November 17, 2014 accident; and 2) whether he had reached maximum medical improvement (MMI) on January 8, 2015 (after a cortisone shot and Synvisc injection) such that his recurring complaints later that year are solely related to his preexisting condition?

Regarding the first question, Petitioner testified that he had previous surgeries, including a hip replacement in 2010 and back surgery in 2007, but no significant prior treatment to his left leg:

Q: Now, have you ever had any significant treatment to your left leg?
A: Not significant, no, that I can recall.
Q: When you say not significant, what do you mean by that?
A: I might have gone into him with a twisted knee or something. I don't recall. Maybe swelling or something. I used to ref basketball and officiate football. So you are going to – you are going to be sore at times at my age doing that. You twist your knee, you get sore ankles or stuff. I went to Dr. Stewart just because he was real good about giving me Tramadol and he would check things out to make sure I wasn't doing any damage that couldn't be reversed.
Q: At the time when this incident occurred in 2014, were you under active treatment with respect to your left leg?
A: No.
Q: Had you ever had a surgery recommendation or a recommendation for a knee replacement with respect to your left leg prior to this incident?
A: No, no.
Q: When you think back can you describe the difference between your left knee before you had this incident versus after you had this incident?
A: Well, before I really - I had no problems with it. You always got sore joints but no lasting pain or you know. I really had no problems with it whatsoever.
Q: What about after?
A: After I mean I still have – when I overdo things. I have had to retire from reffing basketball and doing football. I can't do that anymore. I haven't tried to do it but I think it would just be too painful. *T.24-25.*

On cross-examination, Petitioner was asked about a prior left knee injury in 2010:

Q: I believe you testified you haven't had any left knee many problems in the past; is that correct?
A: Right.
Q: But in fact didn't you have a similar injury to your left knee back in January of 2010?
A: I don't recall if I did.
Q: Were you – you don't recall ever being diagnosed with internal derangement or any tears in your left back in 2010?
A: I don't know the dates. At one time they diagnosed I had a hairline fracture above my knee. It wasn't nothing to do with the knee.
Q: So it is your testimony today that you are not aware of any prior left knee diagnosis?
A: No.
Q: You have been treating with Dr. Stewart for approximately ten years; is that fair to say?
A: Probably.
Q: Primary for osteoarthritis throughout all your joints?
A: I don't know if all my joints. My original when I went to see Dr. Stewart was my hip was giving me a lot of problems. And did the X-rays and MRI and stuff and he said you will need hip replacement. You are going to have to have eventually both hips replaced. He never thought I needed a knee replacement.
Q: Do you recall undergoing a left knee MRI back in 2010?
A: I recall having an MRI, yes. But it wasn't for my left knee. The pain was above it.
Q: Had you sought care with other providers other than Dr. Stewart for your left knee prior to 2014?
A: I don't recall I have, no. *T.31-33.*

On redirect, Petitioner testified:

Q: If you have complained to Dr. Stewart about your left knee on or about 2010 had those problems resolved by 2014?
A: Yes. *T.36.*

The issue is whether Petitioner was credible when he denied having any significant prior left knee problems. The Arbitrator's decision states:

> On 1/6/07 petitioner reported a left knee injury on 1/5/07 when he slipped on ice while getting out of his truck. He was assessed with possible internal derangement of the knee. He had slight medial meniscus tenderness. An MRI of the left knee performed on 1/8/10 showed joint effusion and moderate sized Baker's cyst. *Dec. at 3.*

I would find that this reference to a knee injury on January 6, 2007, is a typographical error by the Arbitrator, because I did not find any records in evidence pertaining to a left knee

injury in 2007. There was, however, a January 6, **2010**, record from Petitioner's primary-care-physician, Dr. VanKerrebroek, which reflects:

> Petitioner here for L knee injury yesterday, very painful. X-ray obtained this morning.
> HPI: Yesterday…slipped on ice while getting out of his truck; hurts in quads but today just in knee; no swelling no erythema; no previous injury; felt something; may have had valgus injury;
> …
> A/P: Suspect internal derangement of knee as P is with slight guarding; he has some anserine tenderness; some slight medial meniscus tenderness; …
> Rx crutches and knee immobilizer; *Px1.*

It was after this visit that the January 8, 2010 MRI was performed and the January 25, 2010 x-ray showed mild degenerative changes. This typographical error is significant because the Arbitrator relied in this alleged 2007 knee injury in the Conclusion section where the Arbitrator wrote:

> It is unrebutted that petitioner does have a preexisting severe osteoarthritis condition that has resulted in a surgery to his lumbar spine, a left hip replacement and a current recommendation for a right hip replacement. **Additionally, it is unrebutted that petitioner had prior problems with his left knee in 2007 and 2010. At those times degenerative changes were noted in the left knee.** *Dec. at 10 (Emphasis added).*

This indicates that the Arbitrator believed Petitioner had left knee problems going back to 2007. However, the evidence does not show that Petitioner had left knee problems in 2007. The only prior left knee problem was in 2010.

So, what was the "problem" in 2010? Petitioner testified, "At one time they diagnosed I had a hairline fracture above my knee. It wasn't nothing to do with the knee." *T.32.* Dr. Stewart's records indicate that he diagnosed Petitioner with a left knee sprain on January 15, 2010. On January 25th, Petitioner's left knee was still bothering him so further tests were ordered. An x-ray showed mild degenerative changes. A CT scan of the left distal femur on January 25th showed a "subtle focal area…involving the anteromedial distal femur approximately 12 cm proximal to the knee joint line." An MRI on February 9, 2010 showed:

> an area of chondromalacia in the medial tibial plateau and some degenerative changes are seen in the medial femoral condyle. … There may be some medullary changes in the bone at that level, but the detail is partially obscured…so [recommend MRI of lower femur to correlate with CT findings].

An MRI of the left thigh was performed on February 16th and the impression was:

> abnormality on CT scan involving the distal one-third of the shaft of the femur…may correspond to stress injury or incomplete fracture w/ surrounding edema and edema of the vastus medialis.

Petitioner underwent physical therapy and by May 7, 2010, Dr. Stewart wrote:

He reports he is feeling great; he is not having any symptoms in the leg. Overall he is feeling significantly better. He has not been running nor doing any formal running.

...

Plan: cont. Ultram and stretching
[Rx L hip injection for hip pain]

Based on the above, I would find that Petitioner's testimony is supported by the evidence. Although he was diagnosed with a left knee sprain in 2010, the MRI showed a "stress injury or incomplete fracture" of the femur. This is not a diagnosis directly related to the knee, which is consistent with Petitioner's testimony. This is also supported by the testimony of Dr. Stewart, Petitioner's board-certified orthopedic surgeon, who testified via deposition on August 11, 2016. He testified that he first treated Petitioner's left knee on January 15, 2010. At that time, his impression was a sprain but Petitioner's MRI did show some early degenerative changes. He testified there was a question about whether Petitioner had a fracture but it was never distinctly labeled as that. Regardless, Dr. Stewart testified that by February 26, 2010, Petitioner was back to work and refereeing basketball. Dr. Stewart testified that, after this incident in 2010, he next saw Petitioner on November 21, 2014, which is after the work accident at issue here. Therefore, I would find that even though Petitioner may have had some "early degenerative changes" in 2010, the medical records do not indicate that these were symptomatic.

I would also point out that Respondent seems to be claiming, and the Arbitrator implies, that Petitioner sought treatment for his left knee in 2012. *Respondent-brief at 7, 9; Dec. at 8.* It appears that Respondent is referring to a January 30, 2012 record of Dr. VanKerrebroeck when Petitioner complained of "arthritis all over." There is a reference in the Active Problems list that includes "Internal Derangement of Knee" and "Knee injury." However, these seem to be "holdover" notations from Petitioner's prior treatment in 2010. The Active Problems list also includes things like abnormal glucose, bulging cervical disc, colonoscopy, medial epicondylitis, and tobacco use. Certainly Petitioner was not "actively" treating for a colonoscopy and the only "assessments" in this 2012 record are "Tobacco use" and "osteoarthritis (bilateral hips)." There is no specific diagnosis for the left knee. It is also noteworthy that many, if not all, of Dr. VanKerrebroek's post-2010 records include the "Internal derangement" problem. This does not mean that it was a problem for which Petitioner was actively treating.

Therefore, it does not appear that Petitioner sought treatment for his left knee in 2012. This is important because Respondent's Dr. Kolb relied, in part, on the fact that Petitioner had sought treatment for his left knee in 2012 to show that he was having previous symptoms.

As further evidence that Petitioner's left knee was asymptomatic prior to his work injury, Petitioner saw Dr. Stewart on November 3, 2014, for right hip pain that started two months prior. Significantly, this record is only 2 ½ weeks prior to Petitioner's work accident and there is no mention of any left knee pain. Therefore, it does not appear that Petitioner's left knee osteoarthritis had been causing him any problems prior to his work accident on November 17, 2014.

Having addressed the first question and finding that Petitioner's pre-existing osteoarthritis was not symptomatic prior to his work injury, the next question is whether Petitioner reached maximum medical improvement on January 8, 2015.

On November 19, 2014, Petitioner completed an accident report with Respondent, which indicated he "slipped on ice -knee buckled" on November 17, 2014. Petitioner testified that he saw Dr. Stewart, at ORA Orthopedics, on November 21st. Petitioner admitted that he has arthritis and had previously treated with Dr. Stewart for a hip replacement. Dr. Stewart's office note from November 21st indicates that Petitioner had left knee pain and, "He was refereeing a basketball game and it started to hurt. No distinct trauma to the region." On its face, this record would seem to contradict a finding of a recent work accident. However, an ORA Orthopedics History Form from the same date *does* indicate that Petitioner "slipped on ice @ work." This would be consistent with the accident report, which Petitioner completed on November 19th. Petitioner was diagnosed with osteoarthritis of the left knee, given a cortisone injection, and returned to work without restrictions.

Petitioner testified that he stopped working on December 2, 2014 (apparently on his own) because his leg was "killing me." *T.20.* There does not appear to be a corresponding office visit record but an "off work" note was signed by Dr. Stewart on December 9, 2014, indicating that Petitioner was off work until "after MRI." This MRI was performed on December 13th and showed:

> Impr.: 1) diffuse degenerative changes of left knee with degenerative-type tearing of the posterior horn of the medial meniscus; 2) acute kissing contusions of the medial femoral condyle and medial tibial plateau without fracture. Lateral stabilizers intact. Mild superficial strain injury of the distal medial collateral ligament; 3) moderate joint effusion. Large post Baker cyst which has partially ruptured with tracking deep soft tissue fluid.

A January 5, 2015 work note states that Petitioner could return to work with no restrictions. On January 8, 2015, Dr. Stewart performed a Synvisc injection in the left knee. Petitioner testified that Dr. Stewart told him that it could take six weeks before it took full effect. *T.21.*

Petitioner began seeing Dr. Vandevelde, D.C. on February 2, 2015 and by February 13th the records show:

> Dr. Vandevelde, D.C.:
> Petitioner states that he can barely feel his knee pain. He states that he is currently on an anti-inflammatory and states that he can tell that the medication has improved the swelling.
> 2/10 intermediate dull pain; 5/10 stiffness
> ...
> Exam: ...palpation revealed the L knee to be subluxated w/ a moderate degree of reduced mobility; ... moderate measure of muscle hypertonicity; ... moderate tenderness elicited in L knee;

There is a gap in treatment at this point, which is the basis of the Arbitrator's decision. Petitioner testified that it seemed like the shots helped and he was asked:

Q: Did they ware [sic] off?
A: Evidently because in the fall it got to hurting so bad that I had to have – I went back in to see him. I had to have something done. *T.21.*

A record of Dr. Vankerrebroek, on September 10, 2015, is mostly about Petitioner's unrelated spinal stenosis but also mentions "L knee and hip bother him more."

On October 15, 2015, Petitioner returned to Dr. Stewart with complaints of the left knee and right hip. This record also indicates, "He has had to stop officiating due to pain in the left knee and right hip." Dr. Stewart diagnosed end-stage osteoarthritis and recommended a left total knee replacement (TKR), which was performed on December 17, 2015. Petitioner testified that he returned to his regular job on February 19, 2016. *T.23.*

Dr. Stewart testified that, after early 2010, he next saw Petitioner on November 21, 2014. He testified that his office note from that day does not reflect that Petitioner had slipped on ice on or about November 17th, but the medical history form from that date does state that Petitioner slipped on ice and he was having pain in the left knee. Dr. Stewart's impression was osteoarthritis, for which he performed a cortisone injection. In January 2015, he performed a Synvisc injection. Petitioner returned on October 15, 2015 and Dr. Stewart recommended the total knee replacement. Dr. Stewart testified that there is a causal relationship between the incident, when Petitioner slipped on ice, and his diagnosis and need for surgery because, prior to that, Petitioner was functioning well. Dr. Stewart opined that incident aggravated the osteoarthritis and pushed Petitioner "over the edge" to needing the knee replacement.

On cross-examination, Dr. Stewart testified that he was not aware of any left knee treatment prior to 2010 but Petitioner certainly could have had internal derangement of the knee at that time. He was not aware of Petitioner seeking care with other providers after 2010 for his left knee. He agreed with the radiologist that Petitioner's December 2014 MRI showed degenerative-type tearing. However, Petitioner also had a work injury "so it was all part of it." After he performed the Synvisc injection, Petitioner was still under treatment at that point but it wasn't debilitating enough to do a knee replacement. He testified that Petitioner was trying to "tough it out" for those months and was unsuccessful. When Petitioner returned to him in October 2015, Petitioner's condition had progressed enough over those nine months to warrant the TKR. Regarding whether Petitioner sought treatment in 2012, Dr. Stewart opined that going two years without treatment would break the causal connection but a 9-month gap would not. He testified that, although osteoarthritis can get worse over time, Petitioner's change from January to October 2015 was a "rapid" and "sharp progression." Dr. Stewart couldn't say for sure whether Petitioner would have needed a TKR regardless of any work injury. He explained that some patients come in with horrendous x-rays who never undergo it. He testified that Petitioner's knee condition "all changed" and rapidly progressed after the work accident. On redirect, Dr. Stewart testified that cortisone has a more immediate effect while Synvisc typically provides relief in 4-6 weeks, and it can be reinjected every 6 months.

Respondent's Dr. Kolb, also a board-certified orthopedic surgeon, performed a records review on March 15, 2016 and testified via deposition. In his opinion, there were no acute findings on Petitioner's MRI but that Petitioner potentially had a strain and a temporary aggravation of his chronic degenerative condition. He opined that any symptoms after 6 weeks would be related to Petitioner's underlying condition. He testified that there was no report of any work injury contained in Dr. Stewart's November 21, 2014 record. However, I would point out that it does not appear Dr. Kolb was aware of the medical history form completed by Petitioner on the same date, as discussed above.

Dr. Kolb testified that Petitioner's TKR was in no way related to the November 2014 injury. On cross-examination, Dr. Kolb agreed with Petitioner's diagnosis and treatment recommendations. He also referenced the January 30, 2012 record of Dr. Vankerrebroek, in which the active issues included "internal derangement of the knee." I addressed the reliability of this record above and find that Petitioner did not actually treat for his left knee in 2012. Since Dr. Kolb relied on this record and based his opinion on the mistaken belief that Petitioner had pre-existing osteoarthritic left knee complaints in 2012, I find his opinion unpersuasive.

Dr. Kolb testified that it is possible for a degenerative tear to become aggravated or caused to be symptomatic by a traumatic event. He agreed that there was no specific recommendation for a TKR until after November 2014. Dr. Kolb also admitted that Petitioner may have had some symptomatic relief following the cortisone injection and that the symptoms may come back. He testified that surgery would only be performed if it was accompanied by significant pain. On redirect, he testified that the 2010 MRI showed degenerative changes. On re-cross, he testified that there is no way one can tell from an MRI whether degenerative changes are symptomatic or not.

It is important to note that the Arbitrator partially based her causation finding on the fact:

> that following the injury on 11/17/14, petitioner had only two visits with Dr. Stewart between 11/17/14 and 1/8/15. Thereafter, petitioner resumed his regular duty work and refereeing activities. Petitioner performed these duties for the next 9 months without any incident. *Dec. at 13.*

However, it is important to consider that the January 8, 2015 visit was when Dr. Stewart performed the Synvisc injection. Dr. Stewart testified that Synvisc typically provides relief in 4-6 weeks and can be reinjected every 6 months. Petitioner testified:

Q: What did you notice while you were performing your job activities when you returned back in 2015?
A: It was sore. I had discomfort. He had given me Tramadol and told me to take Tylenol and things to get, you know – the shot sometimes it takes 6 weeks you know before it takes full effect.
Q: Did you notice that the shots he gave you did have an effect?
A: Seems like it helped.
Q: Did they ware [sic] off?
A: Evidently because in the fall it got to hurting so bad that I had to have – I went back in to see him. I had to have something done. *T.21.*

Later, Petitioner testified:

> Q: Between the time between when this happened in November of 2014 and you had the surgery, did you ever get completely better with respect to your left knee?
> A: In April, May, early summer I thought everything was going pretty good. I didn't feel it was restricting me a lot. Like I say I wasn't going out and jogging like I used to. I was pampering it. But then in the fall it just started – I don't know if the shots wore off. It started getting worse and worse and I think it was in October when I finally went in to him and said we got to do something. He said Duane, the only…thing is to have total knee replacement. *T.26.*

On cross-exam, Petitioner testified:

> Q: And you testified in April or May you thought you were doing well?
> A: I thought I was doing pretty good. *T.34-35.*

I find it completely reasonable that Petitioner's left knee would improve for a period of time after the Synvisc injection and, when it wore off, he began having pain again. Even Dr. Kolb testified that Petitioner may have had some relief to his symptoms after the cortisone injection. *Rx1 at 30.* He testified:

> A cortisone injection is performed for symptomatic relief. It tries to get rid of the pain people are having from an arthritic condition. The symptoms may come back or oftentimes the symptoms can abate for a period of time. *Id.*

Dr. Kolb also admitted that a TKR would only be performed if the underlying arthritis was accompanied by significant pain. *Id. at 31.*

Based on all of the above, I would find that Petitioner's left knee osteoarthritis was not symptomatic and he did not have treatment for it prior to his work accident on November 17, 2014. There was certainly no recommendation for a TKR until after the accident. It is true that Petitioner experienced a period of minimal, if any, symptoms for about 7 to 9 months after his cortisone and Synvisc injections but this is a reasonable period of temporary relief that would be expected following the injections. To find that Petitioner's work accident was not even "a" contributing factor, one would have to find that Petitioner would have required a TKR on December 7, 2015, regardless of whether he sustained the accident at work. This seems speculative since it was the work accident that caused his left knee to become symptomatic in the first place. Even with the gap in treatment, it seems more likely than not that the work injury hastened Petitioner's need for a TKR. Therefore, I would reverse the Arbitrator's decision on causation. I would furthermore award temporary total disability, medical, and increased permanency benefits.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAKESTRAW, DUANNE
Employee/Petitioner

Case# **14WC043598**

STANDARD FORWARDING COMPANY
Employer/Respondent

18IWCC0143

On 9/26/2016, 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:

0412 RIDGE & DOWNES
KARIN CONNELLY
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

2904 HENNESSY & ROACH PC
PAUL N BERARD
2501 CHATHAM RD SUITE 220
CHAMPAIGN, IL 61704

18IWCC0143

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

DUANNE RAKESTRAW,
Employee/Petitioner

v.

STANDARD FORWARDING COMPANY,
Employer/Respondent

Case # 14 WC 43598

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 **9/7/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 11/17/14, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $69,058.07; the average weekly wage was $1,328.04.

On the date of accident, Petitioner was 56 years of age, *married* with no dependent children.

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

Respondent *has or will* paid all appropriate charges for all reasonable and necessary medical services from 11/17/14 through 1/8/15.

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 is entitled to temporary total disability benefits, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services for petitioner's left knee from 11/17/14 through 1/8/15, 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 $735.37/week for 10.75 weeks, because the injuries sustained caused the 5% loss of the left knee, 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

9/22/16
Date

ICArbDec p. 2

SEP 26 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 56 old semi-truck driver/spotter, alleges he sustained an accidental injury to his left leg that arose out of and in the course of his employment by respondent on 11/17/14. Petitioner has worked for respondent for 23 years as a semi-truck driver/spotter. His duties included moving trailers from the warehouse, in and around the plant for the past 13 years. Before that he was an over the road truck driver.

Prior to the incident on 11/17/14 petitioner had a long history of back and left hip problems. He also had prior left knee complaints and treatment. Petitioner underwent surgeries to both his back and his left hip. Petitioner underwent conservative treatment for his back, and eventually underwent a L5 laminectomy with partial laminectomy of L4 and S1, foraminotomy of the right L5-S1, and a discectomy on the right atL5-S1, on 10/17/07. For the osteoarthritis in his left hip petitioner underwent injections and eventually underwent a left hip replacement on 11/20/10, and subsequent exchange of liner and head. Petitioner was released from care on 8/2/11. On 11/3/14 petitioner began treating for his right hip. Treatment options were discussed and petitioner stated that he wanted to hold off on a right hip replacement until October of 2015.

On 1/6/07 petitioner reported a left knee injury on 1/5/07 when he slipped on ice while getting out of his truck. He was assessed with possible internal derangement of the knee. He had slight medial meniscus tenderness. An MRI of the left knee performed on 1/8/10 showed joint effusion and moderate sized Baker's cyst. Also noted was some increased signal extending superiorly in the posterior knee that could represent some edema in between some of the muscular bundles; myxoid degeneration of the posterior horn of the medial meniscus; and marked loss of articular cartilage on the undersurface of the medial femoral condyle. On 1/15/10 Dr. VenKerrebroeck assessed a left knee sprain. On 1/25/10 diagnostic testing showed some mild thinning of the medial compartment articular cartilage; small osteophyte on the patella; and mild degenerative changes. An MRI of the left knee performed 2/9/10 showed an area of chondromalacia in the medial tibial plateau and some degenerative changes in the medial femoral condyle. Also noted was some periosteal reaction in the medial side of the distal femoral shaft; possibly some medullary changes in the bone at that level. An MRI of the left thigh showed T1 and T2 abnormality that may correspond to a stress injury or incomplete fracture with surrounding edema and edema of the vastus medialis. On 2/26/10 petitioner reported some pain with difficulty with running or quicker movements. On 3/25/10 he reported that he was feeling great, and had no symptoms in the left leg.

Petitioner testified that the weather on 11/17/14 was cold, icy, rainy and snowy. He testified that as he was getting out of the semi-truck at about 10:00 am to move a jack stand he slipped on ice as he stepped on the ground, and his feet when out from underneath him. Petitioner grabbed the handrail and his left knee buckled. Petitioner did not fall to the ground. Although petitioner's left knee was sore following the incident, he

continued working for the rest of the day. When petitioner finished his shift at 2:00 pm he testified that his left leg was sore and hurt. Petitioner thought it would get better, but instead it got continually worse. He testified that he had a similar injury in January of 2010 and was diagnosed with internal derangement and tears in his left knee. He also testified that he had a hairline fracture above his left knee at that time.

At some point following the incident petitioner testified that he called Terry Derricks, the terminal manager. He could not recall when. Petitioner then testified that on 11/19/14 he called Kelsey, who works in Safety Department, and told her that he fell on ice and hurt his knee. He testified that he called Kelsey probably after Derricks told him to. He testified that she did not respond to him on 11/19/14, but did later. He stated that he initially thought it was manageable, but by the end of the week sought care when it was not better.

On 11/19/14 petitioner completed an accident report. He wrote that he slipped on ice and his knee buckled. He identified the accident date as 11/17/14. He could not recall how it got from Davenport to the respondent's office in East Moline.

On 11/21/14, after work, petitioner presented to Dr. Mark Stewart for his left knee. He completed a Medical History Form. He reported that he was being seen for his left knee after he slipped on ice at work. He reported medial pain, posterior tightness and some swelling at times. Petitioner noted that he had had x-rays for this problem. Petitioner had previously treated with Dr. Stewart for a left hip replacement, and his arthritis. Petitioner testified that he would get pain medication for his arthritis from Dr. Stewart. Petitioner complained of pain in his left knee. He denied any new trauma to the region. He reported that he was refereeing a basketball game and it started to hurt. He denied any distinct trauma to the region. He stated that walking and stairs bother him, and resting helps. Dr. Stewart examined petitioner. He noted no swelling, and that both knees were stable. Petitioner's muscle strength was 5/5 in his quadriceps and hamstrings bilaterally. His range of motion was 0 to 130 degrees. Dr. Stewart's impression was osteoarthritis of the left knee. An x-ray of the left knee showed medial compartment degenerative joint disease of the left knee. Treatment options were discussed and petitioner elected to undergo a cortisone injection to the left knee, which Dr. Stewart performed. He was told to perform duties as tolerated and return as needed. Dr. Stewart issued a return to work note returning petitioner to work without any restrictions.

Four x-rays of the left knee taken on 11/21/14 showed mild medial compartment joint space narrowing progressive since 2010. No acute soft tissue, joint, or bone abnormalities were noted. Also, no fracture or effusion was noted. The impression was medial compartment degenerative joint disease of the left knee.

Petitioner testified that he notified respondent on 11/24/14 of his injury after he saw Dr. Stewart on 11/21/14.

Petitioner continued working and on 12/2/14 called Derricks and told him he could not work anymore due to the pain. Petitioner testified that he was off work from 12/2/14 through 1/2/15.

On 12/9/14 petitioner did not present to Dr. Stewart. However, Dr. Stewart did issue a return to work note that took petitioner off work until after MRI.

On 12/13/14 petitioner underwent an MRI of the left knee. The impression was diffuse degenerative changes of the left knee with degenerative-type tearing of the posterior of the medial meniscus; acute kissing contusions of the medial femoral condyle and medial tibial plateau without fracture; intact lateral stabilizers; mild superficial strain injury of the distal medial collateral ligament; moderate joint effusion; and large post Baker cyst which had partially ruptured with tracking deep tissue fluid.

On 12/31/14, again Dr. Stewart issued a return work note without having examined petitioner. He released petitioner to return to work on 1/5/15 with no restrictions.

On 1/8/15 petitioner returned to Dr. Stewart for followup of his right knee and a Synvisc injection. He denied any new trauma. Petitioner reported that his left knee bothers him with his walking activities. Dr. Stewart again released petitioner from his care and told him to perform activities as tolerated. Petitioner testified that the shots seemed to help.

When petitioner returned to work on 1/2/15 he testified that he was able to perform his job activities, but was still sore and had discomfort. He stated that he took Tramadol and Tylenol.

Petitioner sought no treatment for his left knee between January and October of 2015. During this period petitioner continued to referee baseball games. He testified that between January of 2015 and early summer of 2015 he was doing pretty good. He testified that it was not until the fall that the pain in his left knee returned and began to worsen. Petitioner denied injuring his knee while refereeing.

In August or September of 2015 petitioner presented to Dr. Berry for his unrelated chronic back pain that had been manageable following a prior surgery, with conservative treatment until he was moving some furniture a month ago and had an acute onset of back pain with discomfort and burning down into his right leg. He made no mention of any left knee problems.

On 9/10/15 petitioner presented to Dr. Vankerrebroeck for his spinal stenosis. At that visit he reported that his left knee was bothering him.

On 10/15/15 petitioner returned to Dr. Stewart for his right hip and left knee. He reported that both were bothering him and he could not tell which was bothering him worse, since at various times both bother him differently. He denied any new trauma. He stated that his gait was bothering him. He stated that he had to stop officiating due to pain in the left knee and right hip. X-rays of the left knee and right hip showed end stage osteoarthritis of the left knee. Dr. Stewart noted that both are primary osteoarthritis. He recommended petitioner first undergo a left total knee arthroplasty, with then plan a right total hip arthroplasty in a staged manner approximately 6 weeks after the knee replacement.

On 12/7/15 petitioner underwent a left total knee arthroplasty. Petitioner followed-up post-operatively with Dr. Stewart. This treatment included a course of physical therapy. He testified that after surgery 90% of his pain was gone. He testified that if he is too active he still gets pain. He also testified that most of the time he is pain free.

On 2/19/16 petitioner returned to full duty work without restrictions. He testified that he has worked full duty job without restrictions since being returned to work as a spotter. Petitioner testified that he currently earns more money per hour, but works less hours.

Petitioner testified that currently his left knee will swell after he does too much activity during the day. He stated that after work some days his left knee swells up. Petitioner testified that he is in and out of the truck up to 50-60 times a day. Petitioner also reported some pain at night when he sleeps if his left knee is in a certain position. Petitioner does not take any medication for his pain. He also does not ice or elevate his left knee. Petitioner testified that he also needs a right total hip replacement as a result of his osteoarthritis.

On 3/17/16 Dr. Edward Kolb performed a record review of petitioner at the request of respondent. That record review included records from 10/24/06 through 10/10/15. He also reviewed diagnostic studies. Following this review Dr. Kolb diagnosed petitioner with diffuse osteoarthritis in the lower back, bilateral hips, and bilateral knees status post possible left knee strain on 11/17/14. He noted that there was no mention of an acute traumatic injury in the notes from Dr. Stewart on or around the time of the apparent 11/17/14 incident. Dr. Kolb was of the opinion that petitioner was alleging a slip on the ice on 11/17/14 causing the left knee to buckle, and a second injury on 11/19/14 while getting out of the truck, twisting the left knee. He believed it is possible that petitioner sustained a strain to the left knee on 11/17/14 and/or 11/19/14. He was of the opinion that petitioner had underlying arthritic changes predating the 11/17/14 and 11/19/14 alleged incidents. He was further of the opinion that the imaging studies immediately after the 11/17/14 and/or 11/19/14 incident were consistent with long standing degenerative findings in the left knee. He was of the opinion that the MRI of the left knee on 12/13/14 was consistent with a degenerative meniscal tear and bone on bone changes in the femoral

condyle and medial tibial plateau consistent with a longstanding left knee issue, consistent with the medical records predating the 11/17/14 incident in question. Dr. Kolb was of the opinion that at most petitioner sustained a strain of the left knee which would have resolved in 6 weeks of the injury. He was of the opinion that there is not a causal connection between petitioner's current left knee complaints and the 11/17/14 and/or 11/19/14 incidents, as petitioner's pain is related to his underlying osteoarthritis. Dr. Kolb was of the opinion that petitioner had reached maximum medical improvement by 1/1/15 as it pertains to any incident on 11/17/14 and 11/19/14.

On 7/15/16 the evidence deposition of Dr. Kolb, an orthopedic specialist, was taken on behalf of respondent. He opined that had petitioner sustained an acute injury to his medial meniscus on 11/17/14 or 11/19/14 it would have shown up on the MRI on 12/13/14. He also noted that with acute tears there will be evidence of an effusion in the knee with potentially surrounding edema in the bones and affected compartment, and none was seen on the MRI. Dr. Kolb was of the opinion that it is possible for someone to experience pain from an arthritic knee without aggravating or exacerbating the underlying arthritis. He was of the opinion that arthritic knee pain comes and goes and as it progresses over time it typically becomes present on a more continual basis. Dr. Kolb was of the opinion that with a chronic degenerative tear in his menicus petitioner could likely be able to referee basketball games. Dr. Kolb was of the opinion that if petitioner's accident was believed, petitioner potentially had a strain to his knee, potentially a temporary aggravation of his chronic degenerative condition, that would have resolved within 6 weeks. He opined that any knee replacement surgery in December of 2015 would not be causally related to any injury he sustained on 11/17/14 and 11/19/14. He opined that knee replacements are not performed for meniscal tears, but rather for arthritic conditions.

On cross-examination Dr. Kolb admitted that he never examined petitioner, nor did he speak with him.

On 7/28/16 Dr. Stewart drafted a letter to Karin Connelly, petitioner's attorney, in response to petitioner and his case. He noted that petitioner is a patient of his and he has treated him over the past several years for his hips and his left knee. He reported that he saw petitioner on 1/21/14 and evaluated him. He noted that petitioner reported at that point that he was having pain in his left knee and had slipped on some ice. He noted that he had treated petitioner for prior left knee pain on 1/15/10 and that it had resolved with nonoperative management. After that he did not see petitioner for until after the injury on 11/17/14. He noted that at that time petitioner had more pain in the left knee. He reported that he attempted nonoperative treatment of the left knee. He noted that petitioner had degenerative changes to the left knee at that time.

Dr. Stewart opined that there is a causal connection between petitioner's injury on 11/17/14 to his left knee and his work activities. He noted that prior to 11/17/14 petitioner was not having any significant amount of pain

and was functioning fully. Then after the injury he was not able to do his normal activities without a significant amount of pain. Dr. Stewart noted that while he agreed with Dr. Kolb that the degenerative changes in his knee were not caused by the work activities, he believed his work activities aggravated his underlying condition. He was of the opinion that petitioner would benefit from treatment of the left knee, which was first attempted nonoperatively, and then petitioner underwent a total knee arthroplasty on the left on 12/7/15. Dr. Stewart was of the opinion that petitioner had done were very well and was back to doing his activities. He was of the opinion that on 2/18/16 petitioner had excellent motion and strength in the left knee and was returning to officiating games.

On 8/11/16 the evidence deposition of Dr. Stewart, an orthopedic surgeon, was taken on behalf of respondent. Dr. Stewart admitted that his records do not include any history that petitioner had slipped in the course of his employment on ice. He testified that on the medical history form petitioner filled out on 11/21/14 indicates he slipped on ice. Dr. Stewart testified that he did not see petitioner between January 2015 and 10/15/15. He stated that at that time petitioner's history and physical exam were consistent with an osteoarthritis of the knee. He noted that petitioner told him he had to stop officiating due to his left knee pain. At that time Dr. Stewart recommended a left total knee arthroplasty for the osteoarthritis in the left knee. He testified that this surgery was performed on 12/7/15. Dr. Stewart noted that the last time he saw petitioner was on 2/18/16 for follow up of the left total knee arthroplasty. At that time petitioner was planning on returning to officiating and resuming his activities as tolerated, including his work duties. Dr. Stewart opined that the fall on the ice aggravated the osteoarthritis and pushed him over the edge to needing the knee replacement.

On cross examination Dr. Stewart testified that he has been treating petitioner for osteoarthritis throughout his entire body for over 10 years, and petitioner underwent a left hip replacement because of it. Dr. Stewart was of the opinion that petitioner certainly could have had internal derangement in his left knee in January of 2010, but did not seek any treatment for it after 2010. He was unaware of petitioner seeking care for his left knee in 2012. Dr. Stewart testified that he was not aware of any alleged work injury occurring to petitioner's left knee on 11/19/14. Dr. Stewart agreed that petitioner never gave him a history of a work accident on 11/19/14, or 11/17/14. Dr. Stewart was of the opinion that a degenerative tear of the meniscus is a tear that occurs over time and will start to fray and tear and cause degenerative changes. He agreed that the MRI did not show an acute meniscus tear. Dr. Stewart agreed that in all the medical records he dictated personally, he never recorded any alleged work injuries for petitioner. Dr. Stewart noted that in addition to his work petitioner is an official for both softball and basketball. Dr. Stewart was of the opinion that following the injury to his left knee in 2014 where he slipped on the ice, petitioner underwent injections and tried to tough it out and was not able to and

then underwent a total knee arthrosplasty. Dr. Stewart was of the opinion that petitioner's knee had progressed enough over the nine month period between January and September 2015 to warrant the knee replacement. Dr. Stewart admitted that the natural progression of a degenerative condition such as petitioner's osteoarthritis in his knee is that it gets worse over time. He also admitted that he would have expected petitioner's left knee to get somewhat worse from January to October of 2015 as a result of his osteoarthritis, but believed petitioner's progression was rapid during this period. Dr. Stewart agreed that petitioner did not verbally report any injury to his left knee in November of 2014, to him. Dr. Stewart admitted that petitioner could have pain with just his activities of daily living. Dr. Stewart was of the opinion that if petitioner was refereeing the day after the alleged injury running up and down the court that also could be part of the cause of him needing a knee replacement. Dr. Stewart was under the opinion that after the alleged injury on 11/17/14 petitioner cut back significantly on officiating activities. He was of the opinion that petitioner gave up basketball refereeing and only did softball refereeing.

Dr. Stewart testified that after 11/21/14 he never took petitioner off work up until the knee replacement. After the knee replacement he took petitioner off work from 12/7/15 through 2/18/16. Dr. Stewart does not really know what petitioner does at work.

Kelsey Kauzlarich, Safety Manager for respondent, was called as a witness on behalf of respondent. She testified that in 2014 she was the Safety Administrator. She testified that petitioner called her on 11/20/14 and stated that he had injured his left knee on 11/19/14 when he was stepping down from the tractor. At that time petitioner had not yet completed an accident report. Kelsey instructed petitioner to complete an accident report. She also told petitioner to let her know if he sought medical treatment. She testified that she was unaware of any accident on 11/17/14 until she received the accident report. Kelsey testified that petitioner never provided her with any off work slips. She stated that off work notices are required to be on leave.

Kelsey testified that after petitioner returned to work on 1/2/15 he never reported any problems with his left knee to her until he told her about the knee replacement. Kelsey testified that petitioner never provided her with any off work slips.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner claims he sustained an accidental injury to his left knee that arose out of and in the course of his employment by respondent on 11/17/14. It is unrebutted that petitioner has a severe case of preexisting osteoarthritis that had resulted in a back surgery and left hip replacement. Prior to 11/17/14

petitioner also had prior problems with his left knee in 2007 and 2010. In 2010 degenerative changes were seen in the left knee.

Petitioner testified that while stepping out of his truck he slipped on ice and his left knee buckled. He testified that he did not fall to the ground. At some point in the next 2 days petitioner testified that he reported the accident to Derricks, the terminal manager. He also testified that on 11/19/14 he called Kelsey in the Safety Department and reported that he fell on ice and hurt his knee. On 11/19/14 he completed an accident report claiming he slipped on ice and his knee buckled.

Petitioner sought initial treatment for this injury on 11/21/14 with Dr. Stewart. Although he indicated on his intake medical form that he was being seen for his left knee after he slipped on ice at work, Dr. Stewart's medical records for that day do not include any history from petitioner to him that he injured his left knee at work. In fact, during his examination with Dr. Stewart petitioner reported pain in his left knee. He also denied any new trauma to the region. Petitioner told Dr. Stewart that he was refereeing a basketball game and it started to hurt. He denied any distinct trauma to the knee.

Based on the above, although the history documented in Dr. Stewarts medical record of 11/21/14 includes no history of a specific work injury to his left knee on 11/17/14, the unrebutted call to Kelsey, his accident report completed 11/19/14, and his medical intake form for Dr. Stewart, all include a consistent history of a slip on the ice at work on 11/17/14 that caused his left knee to buckle. For this reason, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that he sustained an accidental injury that arose out of and in the course of his employment by respondent on 11/17/14.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Nothwithstanding the finding that petitioner sustained an accidental injury to his left knee that arose out of and in the course of his employment by respondent on 11/17/14, there exists a dispute as to whether or not the petitioner's current condition of ill-being as it relates to his left knee is causally related to the injury he sustained on 11/17/14.

It is unrebutted that petitioner does have a preexisting severe osteoarthritis condition that has resulted in a surgery to his lumbar spine, a left hip replacement and a current recommendation for a right hip replacement. Additionally, it is unrebutted that petitioner had prior problems with his left knee in 2007 and 2010. At those times degenerative changes were noted in the left knee.

Following the accident on 11/17/14, when petitioner presented to Dr. Stewart on 11/21/14 Dr. Stewart examined petitioner and noted that he had no swelling in his left knee and both his knees were stable. He also noted that petitioner's muscle strength was 5/5 in the quadriceps and hamstrings bilaterally. Petitioner's range of motion was 0 to 130. Following this examination Dr. Stewart's impression was osteoarthritis of the left knee. An x-ray of the left knee showed medial compartment degenerative joint disease of the left knee. These x-rays were compared to those taken in 2010 and showed progression of the medial compartment joint space narrowing since 2010. The impression was medial compartment degenerative joint disease of the left knee.

An MRI of the left knee performed 12/13/14 showed diffuse degenerative changes of the left knee with degenerative-type tearing of the posterior of the medial meniscus; acute kissing contusions of the medial femoral condyle and medial tibial plateau without fracture; intact lateral stabilizers; mild superficial strain injury of the distal medial collateral ligament; moderate joint effusion; and large post Baker cyst which had partially ruptured with tracking deep tissue fluid.

Petitioner next followed up with Dr. Stewart on 1/8/15. He underwent a Synvisc injection. Petitioner reported that his left knee bothers him with walking activities. He denied any new trauma.

Between 1/9/15 and 10/15/15 petitioner sought no medical treatment for his left knee. During this period petitioner continued working and refereeing baseball games. At trial petitioner testified that during this time he was doing pretty good. He testified that the pain in his left knee did not return until the fall of 2015 and the worsened to the point where he returned to Dr. Stewart on 10/15/15.

On 10/15/15 petitioner followed up with Dr. Stewart for not only his left knee condition, but also his right hip condition. Petitioner stated that both were bothering him and he did not know which was worse. He also stated that his gait was also bothering him. He testified that at some recent point he had stopped officiating. X-rays of the left knee showed end stage osteoarthritis of the left knee. He recommended a left knee total arthroplasty and right total hip arthroplasty.

Causal connection opinions were offered by both Dr. Stewart, and Dr. Kolb, who performed a comprehensive record review.

Dr. Stewart opined a causal connection between the injury to petitioner's left knee on 11/17/14 and his work activities. He based this on the fact that after this injury petitioner was unable to do his normal activities without a significant amount of pain. The arbitrator finds this opinion not supported by the credible evidence. The arbitrator specifically points to the petitioner's testimony that after he saw Dr.

Stewart on 1/8/15 he was doing pretty good, and had no further pain in his left knee until the fall of 2015. During this period petitioner worked his regular duty job without incident and continued refereeing games. Dr. Stewart opined that petitioner's history and physical examination in October of 2015 were consistent with osteoarthritis of the left knee. Dr. Stewart testified that he has been treating petitioner for osteoarthritis throughout his entire body for over 10 years, and had already performed a left hip replacement because of it. Dr. Stewart admitted that petitioner certainly could have already had internal derangement of his left knee in 2010. He also admitted that the MRI performed in December of 2014 did not show an acute meniscus tear. He also stated that the natural progression of a degenerative condition such as petitioner's osteoarthritis in his left knee is that it gets worse over time. He also admitted that he would have expected petitioner's left knee to get somewhat worse from January to October of 2015 as a result of his osteoarthritis, but he believed the progression was rapid during this period. Dr. Stewart was of the opinion that if petitioner was refereeing the day after the alleged injury on 11/17/14, running up and down the court, that could also be a part of the cause of him needing a knee replacement. Although Dr. Stewart is of the opinion that after the alleged injury on 11/17/14 that petitioner cut back significantly on his refereeing activities, the arbitrator finds no credible evidence to support that until petitioner's left knee pain returned in the fall of 2015.

Dr. Kolb diagnosed petitioner with diffuse osteoarthritis in the lower back, bilateral hips and bilateral knees status post possible left knee strain on 11/17/14. He noted that there was no mention of any acute traumatic injury in the notes of Dr. Stewart on or around the apparent 11/17/14 accident. Dr. Kolb opined that petitioner had underlying arthritic changes that predated the 11/17/14 injury, and the imaging studies immediately after the injury were consistent with long standing degenerative findings in the left knee. He was also of the opinion that the MRI of the left knee showed a degenerative meniscal tear and bone on bone changes in the femoral condyle and medial tibia plateau consistent with longstanding left knee issue. Dr. Kolb opined that there is no causal connection between petitioner's current left knee complaints and the 11/17/14 incident. He opined petitioner's current condition is related to his underlying osteoarthritis. Dr. Kolb opined that had petitioner sustained an acute injury to his left knee on 11/17/14 those findings would have shown up on the MRI on 12/13/14. Dr. Stewart was of the opinion that arthritic knee pain comes and goes and as it progresses over time it typically becomes present on a more continual basis.

Based on the above, as well as the credible evidence, the arbitrator finds the findings and opinions of Dr. Kolb more persuasive, and supported by the credible evidence, than those of Dr. Stewart, and

adopts the opinions of Dr. Kolb and finds the petitioner's current condition of ill-being as it relates to his left knee is not causally related to the injury on 11/17/14. Additionally, the arbitrator bases this finding on the fact that following the injury on 11/17/14, petitioner had only two visits with Dr. Stewart between 11/17/14 and 1/8/15. Thereafter, petitioner resumed his regular duty work and refereeing activities. Petitioner performed these duties for the next 9 months without any incident. This, coupled with the fact that petitioner had severe preexisting osteoarthritis throughout his body for 10 years, and had previously treated for his left knee osteoarthritis in 2010 and at that time already demonstrated bone on bone in the knee, the arbitrator finds the petitioner sustained a strain or temporary aggravation of his severe preexisting osteoarthritis condition in his left knee on 11/17/14, that had resolved on or about 1/8/15. Thereafter, petitioner resumed all activities of work, refereeing activities, and activities of daily living until he had further aggravation and exacerbation of severe preexisting osteoarthritis in his right hip and left knee in October of 2015. The arbitrator also bases this opinion on the fact that petitioner did not fall on his left knee on 11/17/14, and all imaging studies performed after the injury showed no acute findings, but rather a continuing progression of his severe preexisting osteoarthritis.

As a result of the injury to petitioner's left knee on 11/17/14, the arbitrator finds the petitioner only sustained a temporary aggravation of his severe osteoarthritis in his left knee that had resolved by 1/8/15. The arbitrator finds the petitioner's condition of ill-being as it relates to his left knee after 1/8/15 causally related to his severe preexisting osteoarthritis condition and not the injury on 11/17/14.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found the petitioner's current condition of ill-being as it relates to his left knee is not causally related to the injury on 11/17/14 after 1/8/15, the arbitrator finds the treatment petitioner received for his left knee from 11/17/14 through 1/8/15 was reasonable and necessary to cure or relieve petitioner from the effects of the injury he sustained to his left knee on 11/17/14.

Respondent shall pay reasonable and necessary medical services for petitioner's left knee from 11/17/14 through 1/8/15, 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.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner claims he was temporarily totally disabled from 12/2/14 through 12/31/14 and 12/7/15 and 2/18/16. Respondent claims it is not liable for any temporary total disability benefits.

Having found the petitioner's current condition of ill-being as it relates to petitioner's left knee is only causally related to the injury petitioner sustained on 11/17/14 through 1/8/15, the arbitrator finds the period of 12/7/15 through 2/18/16 is denied.

With respect to the period 12/2/14 through 12/31/14 the arbitrator finds the petitioner is also not entitled to any temporary total disability benefits. The arbitrator bases this opinion on the testimony of Dr. Stewart, who stated that he never authorized petitioner off work prior to 12/7/15. Additionally, the arbitrator notes the testimony of the petitioner who stated that it was his decision to stop working on 12/2/14 despite the fact that Dr. Stewart did not give him any off work restrictions on 11/21/14 and the fact that petitioner did not again present to Dr. Stewart until 1/8/15.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner is not entitled to any temporary total disability benefits.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

As a result of the accident on 11/17/14 petitioner sustained a strain of the left knee that resolved by 1/8/15.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, petitioner is a spotter that enters and exits the cab of a semi 50-60 times a day. Petitioner testified that he continues to perform these duties today. Based on these facts, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 56 years old at the time of the accident. Since the accident petitioner has returned to his full duty job without restrictions and continues to fulfill all aspects of his job without incident. Based on these findings, the Arbitrator therefore 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 stated that his wages have increased, but his hours are less. He did not attribute this loss of hours to his injury. Because of this the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator has adopted the opinions of Dr. Kolb and finds the petitioner had reached maximum medical improvement as of 1/8/15. Following the injury petitioner had only 2 visits with Dr. Stewart between 11/17/14 and 1/8/15. All diagnostic tests showed no acute injury to petitioner's left knee. Following his release from care on 1/8/15 petitioner testified that he continued to work his full duty work activities, as well as his refereeing activities through the fall of 2015 without incident or any further treatment. In October of 2015 returned to Dr. Stewart for new complaints of pain that began in the fall of 2015 and were related to his preexisting osteoarthritis in his left knee and right hip. Due to petitioner's 9 month gap in treatment and/or complaints as they relate to his left knee, the arbitrator finds the petitioner had reached maximum medical improvement as it relates to his left knee injury on 11/17/14 on 1/8/15. All treatment after that is causally related to his preexisting osteoarthritis, and not the left knee strain he sustained on 11/17/14.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained a permanent partial disability to the extent of 5% loss of use of left knee pursuant to §8(e) 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

Scott E. Gooch,

Petitioner,

vs.

NO: 13WC 34861

18IWCC0144

SIH/Herrin Hospital,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 1, 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.

18IWCC0144

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 $44,000.00. 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: MAR 1 2 2018
o030618
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

GOOCH, SCOTT E
Employee/Petitioner

Case# **13WC034861**
14WC040497

SIH/HERRIN HOSPITAL
Employer/Respondent

18IWCC0144

On 8/1/2017, 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 1.13% 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:

1167 WOMICK LAW FIRM CHTD
CASEY VAN WINKLE
501 RUSHING DR
HERRIN, IL 62948

0693 FEIRICH MAGER GREEN RYAN
D BRIAN SMITH
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

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

SCOTT E. GOOCH
Employee/Petitioner

v.

SIH / HERRIN HOSPITAL
Employer/Respondent

Case # 13 WC 34861

Consolidated cases: 14 WC 40497

18IWCC0144

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 24, 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 **Res Judicata / Law of the Case**

FINDINGS

On the date of accident, **July 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 *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$42,432.00**; the average weekly wage was **$816.00**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$28,258.65** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$28,258.65**.

Respondent is entitled to a credit for **ANY AND ALL BILLS PAID** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $544.00 per week for 45 weeks, commencing October 21, 2013 through August 31, 2014, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $28,258.65 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $48,226.14, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any and all medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

The Petitioner has failed to prove that the requested prospective medical treatment, namely the L4-5 and L5-S1 surgery proposed by Dr. Gornet, is reasonable and necessary based on the preponderance of the evidence. Therefore, the Petitioner's claim for prospective medical 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.

18IWCC0144

Signature of Arbitrator

July 11, 2017
Date

AUG 1 – 2017

STATEMENT OF FACTS

Petitioner, who worked as a nurse for Respondent, filed an initial claim (13 WC 34861) involving a claimed 7/1/13 accident (the "first accident"). He then filed a second claim (14 WC 40497) for a 10/26/14 accident (the "second accident"). (Arbx3 & 4).

The initial matter regarding the 7/1/13 accident was previously tried pursuant to Section 19(b) before a previously assigned Arbitrator on 12/2/14. (Px12). That Arbitrator issued a 1/28/15 decision, which the current Arbitrator adopts and incorporates herein.

The current hearing was held on 10/24/16 pursuant to Section 19(b) with regard to both accidents. (Arbx1 & 2). Petitioner moved to consolidate these claims prior to the hearing, which was granted by the Arbitrator without objection. Petitioner further moved to amend the date of accident listed in his Application For Adjustment of Claim for the second accident from 10/26/14 to 10/22/14, which was also granted without objection from Respondent.

Issues in dispute as it relates to the first accident are medical expenses, TTD, prospective medical, and whether Petitioner is estopped from pursuing the issue of prospective medical under res judicata/the law of the case doctrine by virtue of the previous Arbitrator's prior decision. Issues in dispute as it relates to the second accident include causation, medical expenses, TTD, and prospective medical. (Arbx1 & 2).

The prior hearing in 13 WC 34861 (Px12) involved the issues of causation and prospective medical care, namely, an L4-5 disc replacement and L5-S1 fusion as recommended by Dr. Gornet. The Arbitrator found that Petitioner's condition of ill-being was causally related to the first accident, but denied Petitioner's request for prospective medical treatment. The Arbitrator stated: "Petitioner's current condition of ill-being in his lumbar spine is causally related to his accident; however, Petitioner failed to prove the prospective medical treatment recommended by Dr. Gornet is reasonable and necessary treatment; therefore, Petitioner's claim for prospective medical is denied." The basis for the denial was based on three factors. First, the Petitioner had not been seen by any surgeon for his low back or radicular symptoms since seeing Dr. Jones a year prior to the hearing. Secondly, Petitioner had returned to work. Finally, Petitioner testified that after returning to work, he sustained a new injury to his low back, for which he had been referred to physical therapy and had undergone a new MRI. Under those circumstances, the Arbitrator determined that it would be "entirely inappropriate" to award the recommended surgery, and declined to speculate at that time whether, in light of the new injury, the surgery recommended by Dr. Gornet was reasonable and necessary absent a fully informed medical opinion. The Arbitrator made no specific conclusions with regard to the opinions of Dr. Gornet, Dr. Zelby and Dr. Treister regarding the reasonableness and necessity of this proposed surgery; her denial of this treatment was based solely on the reasons stated above.

Petitioner offered the transcript of the 12/2/14 hearing into evidence in the instant case. At that time, the Petitioner testified in response to the question how his back was doing as follows: "Not well. I'm sitting at a desk most of the day. I do get up and walk around, but it does cause increased pain, discomfort. I do have tingling sensations down both legs all the way to the toes since this injury has occurred." (Px19).

Approximately three weeks prior to the second accident, Petitioner saw his primary care physician, Dr. Hays, on 10/2/14. On that date, Petitioner's subjective complaints consisted of low back pain with radiation down both legs. Dr. Hays noted Dr. Gornet's lumbar surgical recommendation. He described Petitioner as "acting like an old man," and moving slowly. Dr. Hays wrote Petitioner a prescription for 120 tablets of Norco on this date. (Rx27).

This 10/2/14 note was consistent with Dr. Hays' notes in the months prior to the second accident. On 7/10/14, Dr. Hays noted chronic back pain, Dr. Gornet's surgical recommendation, and prescribed 120 tablets of Norco. On 8/7/14, Petitioner followed up with Dr. Hays for chronic low back pain. On 9/24/14, Dr. Hays documented that Petitioner continued to hurt, that his activities were limited, and that his pain inhibited his activities. (Rx27).

The Arbitrator further notes that Petitioner suffered from anxiety and depression prior to the first accident, and was taking antidepressants at the time of the first accident. (Px12).

The Petitioner testified that on 10/22/14, while on duty, he was advised that a patient's husband was having a heart attack, and when he went to help, the man appeared to be having a seizure. Trying to hold him in a seat that was sliding, while the man was jerking forward and back, the Petitioner testified that he had a significant aggravation of his low back condition. He testified that he had increased back pain, right greater than left, and testified: "I still had the pain to the back of the [right] knee, numbness and tingling in both legs and feet."

Prior to this incident, the Petitioner testified that an L4/5 disc replacement and L5/S1 fusion had been prescribed by orthopedic surgeon Dr. Gornet. Asked what had changed from his previous symptoms, Petitioner testified that his pain now radiates to the left side and that his low back pain in general has increased. He saw Dr. Gornet after this accident, and the doctor continues to recommend the same surgery. Petitioner testified he restricted him to sedentary duty, which the Respondent accommodated, until approximately 2/19/16. At that time he was approached by the Respondent's Stephanie Phillips with a letter from Respondent's Section 12 examiner, Dr. Zelby, stating that there was nothing wrong with him and he was able to return to full duty work. Petitioner did not agree with this, indicating that he spoke to his attorney and felt he was within his rights to decline a return to full duty. He hasn't worked since that time.

Since that time he has continued to treat with Dr. Hays and Dr. Gornet, which includes medications and a home exercise program, while Dr. Gornet has maintained him on work restrictions. Petitioner testified that he wants to have the recommended surgery.

Petitioner was seen at WorkCare, the occupational medicine clinic, on 10/27/14. Petitioner complained of pain from his shoulder blades down to his low back. He denied any history of depression, drug dependence, panic, or stress on this date. His current medications included Percocet, Norco, Prednisone, and Flexeril, as well as Celexa, which is an antidepressant. On physical exam, Petitioner was noted to have pain on motion, pain on palpation, and spasm over the lumbar and thoracic spines. No neurological exams were documented. Petitioner was diagnosed with lumbar and thoracic strains and referred for MRIs of his lumbar and thoracic spines. He also was given light duty work restrictions. (Rx24).

The 10/27/14 lumbar MRI impression was minor degenerative disc disease and minimal/mild facet arthropathy similar to that seen on a July 2013 lumbar MRI. The findings included a small disc bulge and minor facet arthropathy at L4-5 causing mild central canal and bilateral foraminal stenosis, as well as a minimal concentric disc bulge with right paracentral annular fissure at L5-S1 that did not displace the S1 nerve root. The thoracic MRI from the same date indicated facet arthropathy that was minimal at T9-10 and mild at T10-11. A minimal posterior disc bulge was present at T11-12 that did not cause central canal or foraminal stenosis. The remaining levels were normal. (Px16).

On 11/3/14, WorkCare noted no anatomically specific subjective complaints. Petitioner's physical exam results and diagnoses were unchanged from the prior visit and he was referred for physical therapy. (Rx25).

On 11/4/14, approximately two weeks following the second accident, Petitioner was seen by Dr. Hays. Petitioner gave a history of having recently reinjured his back while trying to hold a patient. Dr. Hays documented the following regarding Petitioner's subjective complaints: "His pain level is about the same as it was prior to the first injury he is limited in what he can do as far as his daily activities." (Rx27). At trial, Petitioner testified he trusted that Dr. Hays accurately documented what he told him. Dr. Hays' note indicated he knew Petitioner personally, "as my wife is related to his wife," and had observed him at family functions. (Rx27).

On 11/5/14, Petitioner underwent a physical therapy evaluation at SIH Logan Park Rehab. Petitioner reported he fell on a wet floor in July of 2013, and had been through two rounds of PT. He also gave a history of assisting a patient on 10/22/14, which "knotted him up from shoulder blade down." He reported he was already seeing a surgeon who had offered surgery. He stated he had tingling down both legs to his toes. On exam, sensation was intact bilaterally. Lying straight leg raise testing was positive bilaterally. The plan was therapy twice a week for six weeks. (Rx25).

On 11/17/14, Petitioner returned to WorkCare. Petitioner stated most of his pain was in the lumbar region but it radiated up to his mid thoracic region. He described his lumbar pain as unbearable, and his thoracic symptoms to be moderate. He reported physical therapy had not helped. On exam, Petitioner had pain to palpation and motion over the lumbar and mid thoracic spines, with limited range of motion. There was no decreased sensation noted on exam. Petitioner's diagnoses remained unchanged and continued therapy was recommended. (Rx24).

On 12/3/14, a note from Logan Park Rehab indicated Petitioner reported ongoing pain and no improvement with aquatic therapy. After 9 sessions he was discharged from therapy with "max improvement attained." (Rx25).

On 12/8/14, Petitioner reported to WorkCare that he had low back pain and that his right leg was "giving out." There were no complaints documented concerning the mid thoracic area. On exam, heel and toe walking were able to be performed, otherwise the exam findings were unchanged from the prior visit, with no neurological exam documented. His diagnoses remained unchanged and Petitioner was referred to Dr. Jones. (Rx24)

On 12/12/14, Dr. Hays evaluated Petitioner for an unrelated cardiac condition, and nothing was indicated with regard to the back. (Rx27).

On 1/6/15, Petitioner returned to WorkCare with ongoing complaints of low back pain with no improvement, as well as tingling in both lower extremities. Petitioner's physical exam showed limited range of motion, and pain to palpation over both the lumbar and mid thoracic spines. Petitioner was referred to Dr. Gornet. (Rx24).

On 1/8/15, Dr. Hays noted Petitioner reported some discomfort from prolonged sitting at work, and that he had tenderness and some limitation of motion on physical exam, but no major deficits of coordination or sensation on neurological exam. On 2/3/15, Dr. Dr. Hays noted Petitioner's activity level was limited by back pain. Examination was the same as 1/8/15. Prednisone was prescribed. (Px16).

Also on 2/3/15, Petitioner reported 5 out of 10 low back pain into both legs with paresthesias to WorkCare. Petitioner indicated he had previously been referred to Dr. Gornet in 2013, and that Dr. Gornet wanted to perform a disc replacement and fusion at that time, however workers' compensation did not approve the surgery and "he remains basically in limbo with no improvement at all." On exam, Petitioner had a positive straight leg raise test on the left. On 3/6/15, WorkCare noted 3/10 pain with moderate lumbar, bilateral leg, and thoracic pain. He was referred to Rehab Unlimited for a functional capacity evaluation. (Rx24).

On 3/9/15, SIH Rehab Unlimited noted Petitioner's chief complaint was low back pain with bilateral radicular symptoms with an onset date of 7/1/13, when he slipped and fell at work, though he also reported a "subsequent incident" in October of 2014 with exacerbation of his low back pain. A functional test was recommended. (Rx25).

On 3/13/15, Petitioner returned to WorkCare with unchanged subjective complaints and physical examination. Petitioner's work restrictions were decreased, and he was allowed to lift, push, and pull greater weight. He was referred for physical/occupational therapy. (Rx24).

On 3/19/15, Dr. Hays documented chronic pain in the mid and lower back, radiating down both legs at times. Petitioner denied any loss of sensation or motor strength, and on physical exam, Dr. Hays noted some tenderness and some limitation of motion, but noted no major deficits of coordination or sensation on neurological exam. (Px16).

On 3/25/15 Petitioner underwent an FCE which demonstrated ability to perform 71.9% of the physical demands of his job. He was able to lift 25 pounds, carry 21 pounds, and push/pull 50 pounds. Work conditioning was recommended, and Petitioner underwent same from 3/26 to 4/13/15. (Rx25). On 3/30/15, Petitioner returned to WorkCare describing lumbar pain shooting down his right lower extremity, as well as loss of range of motion in the lumbar spine. The note indicated that symptom magnification was present and described Petitioner's attitude and effort as "fair." (Rx24).

A 4/7/15 FCE showed Petitioner was capable of performing 81.9% of the physical demands of his job. (Rx25).

On 4/13/15, at WorkCare, Petitioner reported 8/10 lumbar pain, with "unrelenting" lumbar, thoracic, and lower extremity pain. Symptom magnification was again noted, Petitioner's attitude was "poor," and his effort was "fair." (Rx24).

On 4/14/15, the physical therapist noted Petitioner had been having issues with muscle spasms. His gait was noted to be slowed, stiff, and guarded. He was forward flexed at the hip. He demonstrated stiff, guarded, and abnormal mechanics on transfers. None of his therapy goals were noted to have been met. Petitioner continued with work conditioning on April 20, 22, 23, 27, and 29, 2015. (Rx25).

On 4/27/15, Petitioner reported spasms in his lower back, in addition to pain radiating down both legs. On physical exam, Dr. Hays noted some tenderness and some limitation of motion. (Px16). Petitioner still had not met any of his physical therapy goals as of 4/30/15, and work conditioning continued through 6/3/15. (Rx25).

On 5/1/15, Petitioner returned to WorkCare. Petitioner reported 7/10 pain in his lumbar and thoracic spines. He again described unrelenting lumbar pain, and his thoracic pain was moderate. No neurological findings were documented on exam. The note documented a decrease in Petitioner's lifting status on his most recent functional progress note from physical therapy. (Rx24).

On 5/28/15, Dr. Hays indicated Petitioner reported he was undergoing physical therapy without progress or success. Petitioner denied any loss of sensation or motor strength, and on physical exam, Dr. Hays noted some tenderness and some limitation of motion, but no major deficits of coordination or sensation on neurological exam. Dr. Hays wrote three prescriptions for Norco, each consisting of 120 tablets, and each able to be filled at different time intervals, as well as Flexeril. (Px16). On 5/29/15, Petitioner again reported unrelenting pain to WorkCare. (Rx24).

On 6/8/15, Petitioner saw orthopedic surgeon Dr. Gornet for the first time following the second accident. Dr. Gornet documented a prior history of a work accident on 7/1/13, and Petitioner's subsequent return to work in September of 2014. Petitioner reported he was subsequently involved in a second accident on 10/22/14, at which time he had increasing pain and symptoms, including up his thoracic spine. Dr. Gornet did not document any physical exam. His reported stated the following: "He did not feel it changed his symptoms significantly. He denies any new neurologic issues with his legs. He continues to still have low back pain, buttock and leg symptoms, particularly on the right side." When compared to Petitioner's 2013 films, Dr. Gornet noted Petitioner's October 2014 MRI still showed the central disc herniation at L4-5 and a central disc herniation/annular tear at L5-S1. Dr. Gornet stated the second accident aggravated Petitioner's underlying condition, changing his symptoms "to some extent", but his working diagnosis remained the same: discogenic pain at L5-S1 and a central disc herniation at L4-5. Dr. Gornet increased Petitioner's lifting restriction from 10 pounds to 25 pounds. Dr. Gornet stated his original recommendation for a fusion at L5-S1 and disc replacement at L4-5 was still appropriate. (Px13).

On 6/9/15, Rehab Unlimited noted that Petitioner was overall benefitting from work conditioning with slow improvement. However, he was discharged from work conditioning on that date per Dr. Gornet and his surgical recommendation. (Rx25).

On 6/19/15, Petitioner described a new complaint of a sharp ache radiating down the left lower extremity at WorkCare. The physical exam was noted to be limited due to Petitioner's complaints of pain, and symptom magnification was again noted. (Rx24).

On 6/24/15, Dr. Hays documented chronic back pain. On physical exam, he noted some tenderness and some limitation of motion, but no major deficits of coordination or sensation on neurological exam. This visit appears to have been mainly regarding a right wrist condition. On 7/23/15, Petitioner reported a recent increase in symptoms of numbness down the right leg which was not present a few months prior. (Px16).

At WorkCare on 7/31/15, Petitioner reported the same subjective complaints as in prior visits, rating his pain at 7/10. Straight leg testing was noted to be positive bilaterally, however McGee's crossed straight leg raising testing was negative. (Rx24). On 8/20/15, Petitioner returned to Dr. Hays and reported an inability to sit for prolonged periods without having numbness in both lower extremities. Physical therapy was reportedly not helpful, and physical exam was unchanged from the previous visit. (Px16).

On 8/25/15, Petitioner returned to Dr. Gornet. His report did not document Petitioner's complaints or exam findings, but rather criticized Dr. Zelby's causation and treatment opinions as they related to the first accident. He disagreed with Dr. Zelby's findings that Petitioner showed signs of symptom magnification, that Petitioner

was at maximum medical improvement as it related to his first accident, and that Petitioner did not require surgical intervention. (Px13).

On 8/27/15, Petitioner returned to WorkCare. He described lumbar, lower extremity, and thoracic complaints. The note indicated that no special tests were able to be performed on exam due to Petitioner's pain. (Rx24).

On 9/16/15, Petitioner returned to Dr. Hays. The note described chronic back pain since the first accident, but made no mention of the second accident. Dr. Hays documented no change in Petitioner's physical exam, which documented only some tenderness and some limitation of motion, but no sensation deficits. Petitioner's Norco prescription was refilled. (Px16).

Petitioner was examined by Dr. Zelby on 9/21/15 at the request of the Respondent. Following the second accident, Petitioner reported to Dr. Zelby complaints of pain around the level of the shoulder blades down to the hips in the middle, and down both sides of the back. Petitioner's reported pain around the upper buttocks, worse on the right, soreness just below both shoulder blades, and numbness circumferentially in both lower extremities, both worst and constantly in his feet. Dr. Zelby performed detailed physical and neurological examinations of Petitioner, which were both normal. Dr. Zelby documented inconsistent behavioral responses, such as positive responses for pain on superficial light tough, pain on simulation, diminished pain on distraction, and non-anatomic sensory changes in the entire right lower extremity. Petitioner's response to a lying straight leg raise test was positive bilaterally, but his response to the same test sitting was negative bilaterally. Petitioner was positive for 4/5 Waddell signs with significant symptom amplification on exam. (Rx16).

Dr. Zelby reviewed Petitioner's 10/27/14 thoracic MRI, and stated it showed mild degenerative changes throughout, and chronic Schmorl's nodes in the mid-lower thoracic region, with no stenosis or impingement at any level. His review of the 10/27/14 lumbar MRI reportedly showed mild degenerative disc disease at L5-S1, more than L4-5, with modest loss of disc space height at L5-S1. There was broad based bulging at L4-5 or modest disc protrusion with mild effacement of the ventral CSF centrally. There was mild left greater than right lateral recess stenosis at that level. At L5-S1, there was a broad based bulging disc and a small paracentral right, partial thickness annular tear. There was no neural impingement at any level. When compared to the previous 7/25/13 MRI, Dr. Zelby noted mild progression of the degenerative changes consistent with the passage of time with no acute or post-traumatic abnormalities. Based on his exam of Petitioner, and his review of Petitioner's records and scans, Dr. Zelby concluded Petitioner's reported second accident did nothing to exacerbate, aggravate, or accelerate the mild degenerative condition in his lumbar spine. Even assuming Petitioner's L5-S1 annular tear was acute, Dr. Zelby stated that annular tears are a self-limiting condition that will heal over three to four months. Although Petitioner's L5-S1 annular tear remained radiographically apparent, it was not a source of Petitioner's pain in the context of his mild degenerative condition, and in no way was a basis to pursue a fusion at that level. (Rx16).

Dr. Zelby found Petitioner's subjective complaints to be inconsistent with the objective medical findings, and inconsistent with the natural history of Petitioner's objective medical condition. There was no medical basis to suggest Petitioner's ongoing complaints were causally related to either his mild degenerative condition in his spine or his purported work accidents. Dr. Zelby opined Petitioner's symptoms were related to symptom amplification, given his normal neurological exam, normal spine exam, and mild lumbar degeneration. He believed Petitioner had reached maximum medical improvement (MMI) relative to the second accident by February of 2015 at the latest, and was safely qualified to work without restrictions. There was no reasonable expectation that surgery would provide Petitioner with meaningful or sustained relief in the context of such mild degeneration. Petitioner required no further diagnostic studies or further treatment directed at his spine irrespective of cause. Dr. Zelby indicated that Dr. Gornet's persistent recommendations for surgical intervention

were inconsistent with spine care necessary for Petitioner's condition, and were not in Petitioner's best interests or the long term health of his spine. (Rx16).

On 10/13/15, Petitioner returned to Dr. Hays. The note documented anatomically nonspecific subjective complaints of back pain, which were worse with activity, and which did not seem to be improving. Dr. Hays again wrote three months worth of Norco prescriptions. On 11/10/15, Dr. Hays noted nonspecific subjective complaints of slightly increased low back pain only, and physical exam was unchanged from the prior visit. (Px16).

On 11/30/15, Dr. Gornet noted a normal physical exam on this date was that it was normal. This was Dr. Gornet's first documented physical exam of Petitioner since the initial visit in 2013. Dr. Gornet did not describe any specific subjective complaints, stating only that Petitioner's symptoms "affect all aspects of his life and his quality of life." Dr. Gornet recommended a CT discogram at L3-4, L4-5, and L5-S1, a new MRI, and MRI spectroscopy. Dr. Gornet continued the same work restrictions for Petitioner. (Px13).

On 12/18/15, Petitioner returned to Dr. Hays. The note documented complaints of back pain radiating down both legs, which Petitioner described as slightly increased lately. Physical exam was unchanged, and Norco was again prescribed. (Px16 at 58-59).

On 12/28/15, Dr. Zelby rendered an impairment rating pursuant to the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition of 5% of the whole person. (Rx17).

On 1/18/16, Dr. Hays noted Petitioner reported that his daily activities were limited due to back pain, and that he stated he could not work for long periods of time or stand for prolong periods of time. His exam was unchanged from his prior visit, with an added subjective notation that Petitioner was more comfortable standing. (Px16).

Also on 1/18/16, Dr. Gornet's proposed surgical intervention was submitted to Dr. Treister for utilization review. Dr. Treister determined that the proposed surgery was not reasonable and necessary. He noted that Petitioner's records demonstrated widespread tenderness, no objective evidence of radiculopathy, and no evidence of relief with prior conservative care. Petitioner also appeared to be on significant quantities of narcotic medication with only limited relief of his symptoms. Dr. Treister further noted that ODG guidelines and other relevant orthopedic literature warn against surgeries on patients with Waddell findings, who are on significant doses of narcotics, and who suffer from depression. In any of those instances, the likelihood of reasonable surgical results is extremely small, but when taken together, there is a very strong evidence in this case that surgery should not be considered. (Rx19).

On 1/22/16, Petitioner returned to WorkCare reporting low back and lower extremity symptoms, with referral into the shoulder blades. Petitioner attributed his symptoms to the first accident, and stated the second accident exacerbated the symptoms. The recommendation was for work conditioning 50% of the time, and working within Petitioner's work restrictions for 50% of the time. (Rx24).

On 1/26/16, Petitioner underwent a work hardening/condition evaluation which showed he was able to perform 85% of the physical demands of his job. His complaints on this date were of aching pain localized in the lower thoracic and low back area. The 7/1/13 first accident was mentioned, but there was no mention of the second accident. On exam, Petitioner had positive bilateral straight leg raise tests, but otherwise a normal neurological exam. (Rx25). At trial, Petitioner testified he was treated by the physicians at WorkCare. He voluntarily agreed to participate in the work conditioning plan, but not the actual return to work portion of the plan. Petitioner testified that as part of the work condition plan, Respondent offered Petitioner light duty work, but he declined

attempting it. Petitioner testified Respondent has a policy of accommodating all light duty work, and that he himself was accommodated by Respondent for several weeks. (Rx21).

Testimony was also offered at trial by Melanie Sanders, who is a nurse manager for Respondent and Petitioner's supervisor. Ms. Sanders confirmed Respondent has a policy of accommodating light duty work, that this policy applied to Petitioner, and that Petitioner's restrictions were accommodated. Ms. Sanders testified Respondent and Petitioner reached agreement that Petitioner would complete what she called a work ready program where Petitioner would spend part of his time with a therapist, and the other part of his time working modified duty. As Petitioner's supervisor, Ms. Sanders testified that she presented Petitioner with the written agreement, and confirmed Petitioner refused to accept the work portion of the agreement. Petitioner continued with work conditioning on February 1, 2, and 5, 2016. (Rx25).

At WorkCare on 1/29/16, Petitioner was to be working 50% and participating in work hardening 50%. His subjective complaints consisted of tingling in the bottom of his feet and back of legs bilaterally, right greater than left. Physical exam was unchanged. Petitioner was to continue the work hardening program 50% of the time, and to continue working within his restrictions the other 50% of the time. (Rx24).

A 2/5/16 SIH Rehab Unlimited progress note documented Petitioner stating Dr. Gornet told him only surgery would fix him. The assessment stated Petitioner demonstrated an ability to return to work on a transitional/gradual return to full duties beginning at the functional levels outlined in the report for one week. Petitioner refused to participate in this transition. A functional progress note from that same date demonstrated Petitioner's ability to perform 86.1% of the physical demands of his job. Petitioner participated in work conditioning at SIH Rehab Unlimited on February 9 and 10, 2016, and underwent a 2/12/16 functional progress exam which documented his ability to perform 88.1% of the physical demands of his job. (Rx25).

On 2/12/16, Petitioner returned to WorkCare, stating Respondent would not allow him to work because his neurosurgeon didn't want him to. He was advised to continue with the 50% work hardening, 50% working with restrictions plan. On 2/19/16, Petitioner declined a physical exam, was noted to have completed work hardening and was discharged from care with an expectation that he would be at MMI in two months. He was released to regular duty work without restrictions as of this date. (Rx24). An FCE on this date indicated an ability to perform 86.4% of the physical demands of his job, however it was noted that Petitioner may have been limited due to a recent discogram. Petitioner was noted to have refused to perform certain portions of this exam. (Rx25).

At trial, Ms. Sanders testified that following Petitioner's full duty release, on or about 2/19/16, she texted Petitioner and asked when he would be available to sit down and look at a schedule. Petitioner replied he was not released from his surgeon and therefore would not be returning to work. Petitioner confirmed this work offer from Respondent in his testimony.

On 3/2/16, Petitioner returned to Dr. Hays. The note described chronic back issues with radicular pain down his right leg, with no mention of his left leg. Petitioner informed Dr. Hays that he had been trying to work, but had not been allowed to do so for the last six weeks because he refused to accept the workers' compensation physician's reports that he was uninjured. Petitioner also reported he tried physical therapy, but was having difficulty with the recumbent bike, stating that after five minutes his groin goes numb. His physical exam on this date showed some tenderness and some limitation of motion, but no major deficits of coordination or sensation. Petitioner was prescribed Ativan. (Px16).

On 3/9/16, Petitioner returned to Dr. Gornet, and he documented Petitioner as having undergone a CT discogram, however no record of a CT discogram was offered into evidence. According to Dr. Gornet, the CT discogram revealed "a provocative disc moderate to severe at L4-5 and severe at L5-S1." This note also implied Petitioner underwent an MRI spectroscopy, however no record of any MRI spectroscopy or the specific results was offered into evidence. According to Dr. Gornet, "the information from MRI spectroscopy correlates with the objective information on CT discogram." Dr. Gornet related Petitioner's symptoms at that time to his first accident of 7/1/13 only, with no mention of the second accident. He recommended the same surgical procedure as before. Dr. Gornet indicated Petitioner would require a new MRI prior to surgery. He noted Petitioner's exam and work status were unchanged. (Px13).

On 3/30/16, Dr. Hays noted Petitioner described a new subjective complaint of radiation down the lateral aspect of an undefined leg into his fifth toe, which Dr. Hays characterized as consistent with the L5 nerve root. His exam was unchanged from the prior visit. Dr. Hays again prescribed Norco. On 4/29/16, Petitioner returned to Dr. Hays, and Baclofen was prescribed. On 5/27/16, Petitioner continued to complain of low back pain radiating down his legs with numbness. No changes in his back examination were documented from his prior visit, and Dr. Hays again prescribed Baclofen. (Px16).

On 6/20/16, Dr. Gornet noted Petitioner's exam and work status were unchanged. He again recommended surgery, relating Petitioner's symptoms and need for treatment to his first accident only, with no mention of the second accident. Dr. Gornet again referenced MRI spectroscopy and discogram results as showing clear information that Petitioner's "disc pathology is symptomatic." Dr. Gornet recommended a stress test and a new MRI. (Px13).

On 6/27/16, Petitioner returned to Dr. Hays. No specific subjective complaints were documented, and the physical exam of Petitioner's back was unchanged from the prior visit. (Px16).

Petitioner returned to Dr. Gornet on 10/6/16, and he documented nonspecific low back pain, which he related to Petitioner's first accident only, with no reference to the second accident. Dr. Gornet also noted mid-back pain, which Dr. Gornet related to Petitioner's second accident. This was Dr. Gornet's first mention of subjective complaints of mid-back pain since June of 2015, when Dr. Gornet documented thoracic pain immediately following the second accident. Dr. Gornet's treatment recommendation was only directed at Petitioner's low back, and consisted of the same surgery recommended previously. His work status remained unchanged. (Px13).

On 10/12/16, Petitioner returned to Dr. Hays. Petitioner told Dr. Hays that he was not allowed to return to work for Respondent. The note stated Petitioner had been diagnosed with a herniated disc and right lumbar radiculitis. No specific subjective complaints were noted, and the physical exam was unchanged from the prior visit. (Px16).

Dr. Gornet was deposed for the second time on 10/19/15. He saw Petitioner for the first time following the second accident on 6/8/15. Following the second accident, Dr. Gornet's recommendation for an L4-5 disc replacement and L5-S1 fusion remained unchanged. At the time of Dr. Gornet's first deposition, Dr. Gornet had reviewed none of Petitioner's medical records other than those of Dr. Jones and an MRI. Dr. Gornet reviewed no other records following his first deposition other than Dr. Zelby's report and the lumbar MRI from October of 2014. (Px17).

On 11/25/13, Dr. Gornet's only documented physical findings were of mild decrease in EHL function and intermittent decrease in sensation in the L5 dermatome. His working diagnosis on that date was of a disc

herniation and annular tear. No physical examination was documented on 6/8/15, and on 8/24/15 no subjective complaints or physical examination was documented. Dr. Gornet testified that Petitioner told him his symptoms were not changed significantly as a result of the second accident. He testified that his understanding was that the character and location of the symptoms had not changed. Petitioner still had structural back pain and still had symptoms of low back pain more to the right side, right buttock, and right posterior thigh. He testified: "The intensity may have obviously increased to some extent but our belief was that the location where it was was still essentially the same. The last visit I think he had symptoms of more bilateral nature. But for the most part, the character and how the symptoms affected his life had not changed." (Px17)

Dr. Gornet testified that whether someone "aggravates" an underlying condition is based on the subjective complaints and whether the medical records support that and how it impacts their life. He saw no meaningful change between Petitioner's first lumbar MRI and his October 2014 MRI. Dr. Gornet opined that Petitioner has a central disc herniation at L4-5, and an annular tear at L5-S1. Dr. Gornet agreed that a disc herniation can be asymptomatic, and that a disc herniation identified on an MRI does not necessarily mean that it requires treatment. The same is true of annular tears, which is why surgeons do not simply operate based on MRI findings. (Px17).

Dr. Gornet has proposed a two-level surgery, including the use of a ProDisc-L disc replacement system at L4-5. The ProDisc-L has been released by the FDA for treatment of one symptomatic level of degenerative disc disease only. The criteria for use of the ProDisc-L includes six months of failed conservative treatment, and Dr. Gornet believed that as of the first time he saw Petitioner, he had gone over six months with conservative treatment, consisting of physical therapy and an injection, and remained symptomatic. (Px17).

Board certified neurosurgeon, Dr. Zelby, testified via deposition on 2/1/16. He had previously examined Petitioner at the Respondent's request. At that time, Dr. Gornet had proposed a two-level surgery consisting of a fusion at L5-S1 and a disc replacement at L4-5, which Dr. Zelby did not agree with. Such a surgery in the context of Petitioner's mild spinal degeneration exceeded the guidelines for treatment based on an objective medical condition. There was no medical indication to suggest or pursue such a surgery because there was no reasonable expectation that it would provide Petitioner meaningful or sustained relief of his symptoms. His testimony was that Dr. Gornet's proposed use of the disc replacement system was not FDA approved. (Rx18).

Dr. Zelby examined Petitioner for the second time on 9/21/15. Petitioner reported he returned to work full duty in September of 2014, and on 10/22/14 sustained the second accident. His subjective complaints were around the upper buttocks, worse on the right than the left, as well as soreness just below the shoulder blades. He also reported numbness circumferentially in both lower extremities, worst and constantly in his feet. He rated his pain at 6 to 9/10, but Dr. Zelby testified Petitioner's 9/21/15 presentation was not consistent with pain at that level. On exam, Petitioner's thoracic and lumbar spines appeared normal. He reported tenderness in the lower and upper gluteal regions, more on the right, even with non-physiologic light touch, which Dr. Zelby identified as a Waddell sign, as a report of severe pain with light tapping on the skin should not elicit pain regardless of a spinal pathology. During the exam, Petitioner reported a loss of sensation to both pin and vibration in the entire right lower extremity, which Dr. Zelby also identified as a Waddell finding and inconsistent with any condition in the spine or the nervous system. Petitioner also reported pain on simulation, meaning on exam Dr. Zelby simulated a load on the spine, but actually loaded the hips, yet Petitioner reported severe back pain. Petitioner had diminished pain on distraction during his exam. He reported pain in his back with straight leg raise lying down, but no pain with straight leg raise sitting up, with Dr. Zelby indicating that these tests should elicit the same responses. (Rx18).

Dr. Zelby testified Petitioner's subjective complaints were not consistent with any objective pathology observed on Petitioner's lumbar MRI. The persistence and severity of Petitioner's subjective symptoms was inconsistent with the objective medical findings, and inconsistent with the natural history of his objective medical condition. Dr. Zelby testified that Petitioner had mild degeneration without neural impingement, a normal spine exam, a normal neurological exam, but tremendous complaints of pain, which just did not fit. Petitioner's symptoms specifically did not correlate to an annular tear at L5-S1. Dr. Zelby opined that this annular tear was more likely than not degenerative, but even if it were acute, he opined that all of the factors that lead to pain from an acute annular tear subside within three or four months. Annular tears are self-limiting problems, and not conditions which require surgical intervention. Petitioner's L5-S1 annular tear was present on his 2013 lumbar MRI, and thus was in no way caused by the second accident. (Rx18).

Dr. Zelby noted there was no physical exam or any subjective complaints noted in Dr. Gornet's 6/8/15 note correlating to any level of Petitioner's lumbar spine. His 8/24/15 note seemed more consistent with a narrative report, and it did not appear from the note that Dr. Gornet actually examined Petitioner on that date. Dr. Zelby noted nothing in records from Occupational Health Clinic or from Dr. Hays that correlated to symptomatic pathology present on either the lumbar or thoracic MRIs. Dr. Zelby opined Petitioner sustained a lumbar strain, in the context of mild degeneration that was fairly normal for Petitioner's age, as a result of the second accident of 10/22/14. Dr. Zelby testified Petitioner had reached MMI long ago from this strain, and was able to return to his regular job without restrictions as of February of 2015 at the latest. Dr. Zelby did not causally relate Petitioner's ongoing subjective complaints to the second accident, or to any pathological condition in Petitioner's spine irrespective of cause. The proposed disc replacement and fusion was not reasonable and necessary treatment irrespective of cause, in Dr. Selby's opinion, and would not be in the best interests of Petitioner's long-term spinal health, as it would not be reasonable and necessary given all the attendant risks. He testified that the data on lumbar disc replacement is not great. Further, the procedure would change the biometrics of Petitioner's pine in a way that it does not need to be changed. (Rx18).

Dr. Zelby gave a 5% whole body impairment rating based on the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition. This impairment rating was based on Dr. Zelby's analysis of Petitioner's condition, and the related modifiers contained in the AMA Guides. (Px18).

Dr. Tresiter was deposed on 2/25/16. (Rx20). A board certified orthopedic surgeon, Dr. Treister performed utilization review on 1/18/16 with regard to the proposed two-level surgery proposed by Dr. Gornet, and determined that the surgery was not reasonable and necessary treatment of Petitioner's condition. (Rx20).

Dr. Treister previously performed a 12/13/13 utilization review for the same two-level lumbar surgery and testified he did not certify the procedure at that time either. Petitioner at that time was likely habituated to narcotics, which was a contraindication for surgery. There was no evidence of any specific focal nerve level of injury in terms of either subjective complaints, or more importantly, objective findings. Petitioner's conservative treatment was not classic conservative treatment for his issues. The proposed surgery was also experimental, and not approved by the FDA, as the disc replacement had been approved for use in single lumbar level, and not multiple level pathology cases. (Rx20).

Dr. Treister's review of Petitioner's post-December 2013 medical records did not change any of his opinions regarding the reasonableness and necessity of the recommended surgery. The proposed use of the ProDisc-L disc replacement is still not an FDA-approved use, as Dr. Gornet's proposed surgery constitutes treating two different levels of degenerative disc disease, which is not an FDA approved use of the device. Dr. Treister testified the package insert for the ProDisc-L from Synthes states the safety and effectiveness of the ProDisc-L has not been established in patients with more than one vertebral level of degenerative disc disease, which was

why the FDA had not approved use of the device for a surgery involving more than one lumbar level. Petitioner has multiple levels of degenerative disc disease in his lumbar spine. (Rx20).

Dr. Treister testified Petitioner's medication regimen consisted of hydrocodone, oxycodone, and celexa, which is an antidepressant, among others. Under the ODG guidelines, surgical intervention is not recommended for patients who are habituated to narcotics because patients who have pain intolerance get very poor results from spinal surgery. The ODG guidelines also state that patients with psychological or psychiatric problems must be thoroughly evaluated in terms of presurgical consideration, as statistics show that patients who have psychiatric problems react very poorly to spinal surgical intervention. Dr. Treister could not identify a psychological evaluation in his review of the records which would support his candidacy for lumbar surgery in light of his records of depression and use of antidepressants. Dr. Treister noted that Petitioner's initial treatment note following the second accident stated he was negative for any history of depression, which was a misrepresentation. (Rx20).

Dr. Treister testified that Petitioner's 10/27/14 lumbar MRI showed some disc space narrowing at L5-S1 with minimal osteophyte formation in the sacroiliac joint, and widespread, very mild degenerative changes in the lumbar spine. Dr. Treister testified that a reference to a 2 mm or 3 mm disc herniation indicates a very small disc protrusion. There was also fairly mild degenerative disc disease in the lower three thoracic levels. Petitioner's subjective complaints to WorkCare on 10/27/14 did not correlate to any pathology observed on either Petitioner's lumbar or thoracic MRIs. The physical findings were diffuse, widespread, and non-focal, and therefore also did not correlate to any pathology present at any level, specifically not to L4-5 or L5-S1. Dr. Treister testified the objective pathology does not cause pain and tenderness all over the spine. In Petitioner's case, there was widespread tenderness all over the lumbar spine in the absence of any bruising, abrasion, spasm, or any other similar finding, and this was potentially a Waddell sign. (Rx20).

Dr. Treister testified that Petitioner's subjective complaints of tingling down both legs to the toes and pain from the head to the lower back at therapy on 11/5/15 did not correlate to any condition of the lumbar or thoracic spines, including L4-5 or L5-S1. Any symptoms relative to pathology from L4-5 and/or L5-S1 have certain classic, specific patterns, and Petitioner's description of subjective complaints does not meet either of these patterns. (Rx20).

Dr. Treister testified that Petitioner had a history of prior injections which did not help with his pain at all. In patients who have objective spine pathology, if corticosteroids are injected into that area, it usually calms the inflammation down around the nerve and gives some relief for a period of time. If a patient reports no relief at all, it speaks against there being any significant, objective, legitimate pathology causing pain, and in his opinion points more towards psychological and functional problems. Dr. Treister reviewed Dr. Gornet's 6/8/15 note indicating the second accident of 10/22/14 did not significantly change Petitioner's symptoms, and did not reflect any physical exam, only a recommendation based on an MRI. This visit took place almost two years after Petitioner's prior visit to Dr. Gornet. He noted Dr. Gornet also did not document any physical exam on 8/24/15. Dr. Treister testified that a surgeon recommending surgical intervention of the spine must document physical findings, even if they are normal, as each exam involves documenting whether there has been any change from the previous exams to see if the neurological condition has gotten worse, remained the same, or improved. Dr. Trestier testified there is no evidence in Dr. Gornet's records supporting the reasonableness and necessity of any surgical intervention, even one less invasive than his proposed surgical intervention. (Rx20).

In Dr. Treister's opinion, Dr. Zelby's documented physical examination included a classic, thorough neuromuscular lumbar exam, documenting all of its components. He noted that Dr. Zelby found Petitioner had multiple Waddell signs, including circumferential numbness in both lower extremities and loss of sensation and

pain on light touch, and that these are not an indication of objective pathology. Dr. Zelby documented no substantive neurological deficit on exam. (Rx20).

Dr. Treister found no evidence in the records and diagnostic scans of any sort of structural issues in Petitioner's lumbar spine that would require surgical intervention. While it was possible that Petitioner could be suffering from some lumbar and thoracic pain due to degenerative disc disease, Dr. Treister testified that the degenerative disc disease was very mild, and that there were no focal findings leading to radicular pain or neurological deficit. Dr. Treister testified Petitioner met none of the indications for spinal surgery under either the ODG guidelines or commonly accepted guidelines. He testified that he has personally performed spinal surgery for four decades, and that such surgery is not performed unless there is focal objective pathology that can reasonably be assumed to be causing the symptoms. This determination must be made by a concurrence of the radiological findings, the subjective complaints, and the objective findings. He opined that a surgeon cannot make a surgical recommendation for a patient who presents with so called back pain with no classic radicular pattern and nothing focal on MRI. In this case, there was no concurrence of Petitioner's radiological findings, subjective complaints, and objective findings. (Rx20).

Dr. Treister described the ODG guidelines as a further refinement of commonly accepted practices. It is not appropriate to operate on patients who are habituated to narcotics, or on patients who have Waddell findings, or where the findings do not correlate, or where the patient had a response to conservative care. In addition to the surgery, Dr. Treister testified no additional diagnostic scans or procedures would be reasonable and necessary treatment for the same reasons. (Rx20).

CONCLUSIONS OF LAW

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

Petitioner is awarded the following medical charges as it relates to his first accident, subject to all appropriate reductions under the medical fee schedule, and subject to any credits for payment of charges by Respondent and by Petitioner's group health insurance, pursuant to Section 8(j):

• Dr. Hays	(DOS: 3/19/15; 4/27/15; 5/28/15; 6/24/15; 7/23/15; 8/20/15; 9/16/15; 10/13/15; 11/10/15; 12/18/15; 3/2/16; 3/30/16; 4/29/16; 5/27/16; 6/27/16; 10/12/16)	$3,154.00
• Herrin Hosp.	(DOS: 3/1/15 to 2/29/16)	$45,072.14
TOTAL		**$48,226.14**

WITH RESPECT TO ISSUE (O), RES JUDICATA / LAW OF THE CASE, THE ARBITRATOR FINDS AS FOLLOWS:

With regard to the issue of Res Judicata/Law of the Case, the Arbitrator finds that these doctrines are not applicable to the current issues in the case at bar.

The Arbitrator's reading of the decision of the prior Arbitrator notes that an argument can be made that it is somewhat internally inconsistent in that it both finds that the proposed surgery is not reasonable and necessary by order, while then indicating in the analysis that the denial of the surgery was based on three factors, none of which indicate a finding that the surgery is not reasonable and necessary. However, the Arbitrator notes that a careful reading of the decision indicates that the order was based on the finding that a determination of whether the surgery was reasonable and necessary was premature based on what was, at the time, a recent new injury, and because the Petitioner had returned to work. The prior decision specifically noted the surgery was denied "at this time" because the case was "absent a fully informed medical opinion."

In the current Arbitrator's view, the prior decision did not make any conclusive findings as to the reasonableness and necessity of the proposed surgery. As such, there can be no finding in this case that the prior determination is the Law or the Case, or res judicata, with regard to the issue of the reasonableness and necessity of the proposed surgery at the point in time of the 10/26/16 hearing.

A finding in the prior hearing that the Petitioner's lumbar condition was not causally related to the 7/1/13 accident would be conclusive, as there would be no conceivable way that the Arbitrator can see where a condition would not initially be related and then become related at a later date. Medical treatment is a different animal. A surgery may be determined to not be reasonable and necessary at some point, and then after obtaining additional medical evidence, could later be determined to be reasonable and necessary. Arbitrators and the Commission have in the past have found that a determination of medical treatment is premature based on the evidence presented. The current Arbitrator's view is that this is exactly what the prior Arbitrator determined.

The Arbitrator finds that the doctrines of "Law of the Case" and/or res judicata are not applicable to the current issue of whether the L4-5 and L5-S1 surgery proposed by Dr. Gornet is reasonable and necessary.

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

It is undisputed that Petitioner seeks the same surgery he sought when this matter previously proceeded to hearing under Section 19(b) on 12/2/14. The Arbitrator has already determined that the decision of the Arbitrator in the prior case does not specifically bar the ability of the Petitioner to seek the surgery in the current hearing. The prior arbitration decision found that the Petitioner's lumbar condition as of 12/2/14 the Petitioner's lumbar condition was causally related to the 7/1/13 accident. The Arbitrator also has determined in case 14 WC 40497 that the Petitioner's 10/22/14 accident did not break the chain of causation of the Petitioner's lumbar condition to the 7/1/13 accident. Thus, the issue is whether the proposed two-level lumbar surgery of Dr. Gornet is currently reasonable and necessary pursuant to Section 8(a) of the Act. Based on the preponderance of the evidence, the Arbitrator finds that the proposed L4-5 and L5-S1 surgeries are not reasonable and necessary.

There are a number of references in the evidentiary record to findings by multiple medical providers reflecting symptoms magnification and/or Waddell signs.

On 4/13/15, WorkCare noted symptom magnification, "fair" effort and a poor attitude from Petitioner. At physical therapy the next day, it was noted that Petitioner was stiff and guarded with abnormal mechanics, and had met none of his therapy goals.

On 9/21/15, Dr. Zelby noted mild degenerative lumbar disc disease, no evidence of nerve root impingement and an otherwise normal exam. He further noted evidence of symptom magnification, noting that there was no

reasonable expectation that the surgery would provide meaningful or sustained relief given the mild degeneration seen. He opined that Petitioner had reached maximum medical improvement by February 2015 at the latest.

Dr. Hays also consistently found minimal abnormal findings on examinations beyond tenderness and limited range of motion.

Dr. Treister testified against the surgery in two ways. First, he indicated that the proposed surgery was not reasonable and necessary given Petitioner's complaints of widespread tenderness, no objective evidence of radiculopathy and no evidence of relief with conservative care to date. He also referenced the significant amount of narcotics the Petitioner was taking, and that ODG guidelines warn against surgery on patients with Waddell sign findings, who are on significant doses of narcotics and who suffer from depression. Secondly, he testified that the disc replacement device Dr. Gornet was planning to use had not been approved by the FDA for use in a surgery where more than one lumbar level was being operated on. As such, he testified that the planned procedure is experimental.

Petitioner's examinations, including neurologically, have been consistently normal. Only Dr. Gornet has made abnormal neurological findings, and even he in his testimony agreed that Petitioner's examinations were generally normal, and this was a big part of why he did not repeat them at each visit. The Arbitrator notes that while Dr. Gornet commented on discogram and MRI spectroscopy findings, neither test was included in the records in evidence, and no detail was provided by the doctor as to the findings. The Arbitrator also has concern with regard to the 2/5/16 note of SIH Rehab Unlimited which noted Petitioner stated that Dr. Gornet told him that nothing short of surgery would fix his problem, in terms of how this may have impacted Petitioner's efforts with conservative treatment. At that point he had improved to what the provider indicated was an ability to perform 88% of his job.

Based on the generally normal examinations, the opinions of Dr. Zelby and Dr. Treister indicating minimal objective findings, the evidence of opinions of symptom magnification, the experimental nature of the proposed surgery per Dr. Treister, the Arbitrator finds that the prescribed L4-5 and L5-S1 surgery is not reasonable and necessary pursuant to Section 8(a) of the Act.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner had been temporarily totally disabled for the period from 10/21/13 to 8/31/14, and the parties stipulated that the Respondent has paid TTD totaling $28,258.65, and is entitled to a credit for any overpayment.

The Petitioner testified that he continued to perform sedentary duty for the Respondent until approximately 2/19/16, at which point he was advised that, based on the opinion of Dr. Zelby, he was capable of returning to full duty employment. At the same time, the early 2016 records from WorkCare appear to indicate that Petitioner was advised to work 50% of the time and to perform work conditioning 50% of the time. Given Petitioner's testimony that he did not return to work under this plan, the determination of Dr. Zelby that Petitioner had reached MMI as of February 2015, and the evidence of symptom magnification, the Arbitrator declines to award further TTD benefits.

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

Scott E. Gooch,

Petitioner,

vs. NO: 14WC 40497

SIH/Herrin Hospital,

Respondent.

18IWCC0145

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 1, 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.

18IWCC0145

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 12 2018
o030618
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

GOOCH, SCOTT E
Employee/Petitioner

Case# 14WC040497

13WC034861

SIH/HERRIN HOSPITAL
Employer/Respondent

18IWCC0145

On 8/1/2017, 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 1.13% 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:

1167 WOMICK LAW FIRM CHTD
CASEY VAN WINKLE
501 RUSHING DR
HERRIN, IL 62948

0693 FEIRICH MAGER GREEN RYAN
D BRIAN SMITH
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

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

SCOTT E. GOOCH
Employee/Petitioner

v.

SIH / HERRIN HOSPITAL
Employer/Respondent

Case # 14 WC 40497

Consolidated cases: 13 WC 34861

18IWCC0145

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 24, 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 _____

18IWCC0145

FINDINGS

On the date of accident, **October 22, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,432.00**; the average weekly wage was **$816.00**.

On the date of accident, Petitioner was **44** 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 **$179.32** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$179.32**.

Respondent is entitled to a credit for **ANY AND ALL BILLS PAID** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove that his lumbar condition is causally related to the 10/22/14 accident.

As a result, no benefits are awarded relative to this claim.

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

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

Signature of Arbitrator

July 11, 2017
Date

AUG 1 – 2017

STATEMENT OF FACTS

Petitioner, who worked as a nurse for Respondent, filed an initial claim (13 WC 34861) involving a claimed 7/1/13 accident (the "first accident"). He then filed a second claim (14 WC 40497) for a 10/26/14 accident (the "second accident"). (Arbx3 & 4).

The initial matter regarding the 7/1/13 accident was previously tried pursuant to Section 19(b) before a previously assigned Arbitrator on 12/2/14. (Px12). That Arbitrator issued a 1/28/15 decision, which the current Arbitrator adopts and incorporates herein.

The current hearing was held on 10/24/16 pursuant to Section 19(b) with regard to both accidents. (Arbx1 & 2). Petitioner moved to consolidate these claims prior to the hearing, which was granted by the Arbitrator without objection. Petitioner further moved to amend the date of accident listed in his Application For Adjustment of Claim for the second accident from 10/26/14 to 10/22/14, which was also granted without objection from Respondent.

Issues in dispute as it relates to the first accident are medical expenses, TTD, prospective medical, and whether Petitioner is estopped from pursuing the issue of prospective medical under res judicata/the law of the case doctrine by virtue of the previous Arbitrator's prior decision. Issues in dispute as it relates to the second accident include causation, medical expenses, TTD, and prospective medical. (Arbx1 & 2).

The prior hearing in 13 WC 34861 (Px12) involved the issues of causation and prospective medical care, namely, an L4-5 disc replacement and L5-S1 fusion as recommended by Dr. Gornet. The Arbitrator found that Petitioner's condition of ill-being was causally related to the first accident, but denied Petitioner's request for prospective medical treatment. The Arbitrator stated: "Petitioner's current condition of ill-being in his lumbar spine is causally related to his accident; however, Petitioner failed to prove the prospective medical treatment recommended by Dr. Gornet is reasonable and necessary treatment; therefore, Petitioner's claim for prospective medical is denied." The basis for the denial was based on three factors. First, the Petitioner had not been seen by any surgeon for his low back or radicular symptoms since seeing Dr. Jones a year prior to the hearing. Secondly, Petitioner had returned to work. Finally, Petitioner testified that after returning to work, he sustained a new injury to his low back, for which he had been referred to physical therapy and had undergone a new MRI. Under those circumstances, the Arbitrator determined that it would be "entirely inappropriate" to award the recommended surgery, and declined to speculate at that time whether, in light of the new injury, the surgery recommended by Dr. Gornet was reasonable and necessary absent a fully informed medical opinion. The Arbitrator made no specific conclusions with regard to the opinions of Dr. Gornet, Dr. Zelby and Dr. Treister regarding the reasonableness and necessity of this proposed surgery; her denial of this treatment was based solely on the reasons stated above.

Petitioner offered the transcript of the 12/2/14 hearing into evidence in the instant case. At that time, the Petitioner testified in response to the question how his back was doing as follows: "Not well. I'm sitting at a desk most of the day. I do get up and walk around, but it does cause increased pain, discomfort. I do have tingling sensations down both legs all the way to the toes since this injury has occurred." (Px19).

Approximately three weeks prior to the second accident, Petitioner saw his primary care physician, Dr. Hays, on 10/2/14. On that date, Petitioner's subjective complaints consisted of low back pain with radiation down both legs. Dr. Hays noted Dr. Gornet's lumbar surgical recommendation. He described Petitioner as "acting like an

old man," and moving slowly. Dr. Hays wrote Petitioner a prescription for 120 tablets of Norco on this date. (Rx27).

This 10/2/14 note was consistent with Dr. Hays' notes in the months prior to the second accident. On 7/10/14, Dr. Hays noted chronic back pain, Dr. Gornet's surgical recommendation, and prescribed 120 tablets of Norco. On 8/7/14, Petitioner followed up with Dr. Hays for chronic low back pain. On 9/24/14, Dr. Hays documented that Petitioner continued to hurt, that his activities were limited, and that his pain inhibited his activities. (Rx27).

The Arbitrator further notes that Petitioner suffered from anxiety and depression prior to the first accident, and was taking antidepressants at the time of the first accident. (Px12).

The Petitioner testified that on 10/22/14, while on duty, he was advised that a patient's husband was having a heart attack, and when he went to help, the man appeared to be having a seizure. Trying to hold him in a seat that was sliding, while the man was jerking forward and back, the Petitioner testified that he had a significant aggravation of his low back condition. He testified that he had increased back pain, right greater than left, and testified: "I still had the pain to the back of the [right] knee, numbness and tingling in both legs and feet."

Prior to this incident, the Petitioner testified that an L4/5 disc replacement and L5/S1 fusion had been prescribed by orthopedic surgeon Dr. Gornet. Asked what had changed from his previous symptoms, Petitioner testified that his pain now radiates to the left side and that his low back pain in general has increased. He saw Dr. Gornet after this accident, and the doctor continues to recommend the same surgery. Petitioner testified he restricted him to sedentary duty, which the Respondent accommodated, until approximately 2/19/16. At that time he was approached by the Respondent's Stephanie Phillips with a letter from Respondent's Section 12 examiner, Dr. Zelby, stating that there was nothing wrong with him and he was able to return to full duty work. Petitioner did not agree with this, indicating that he spoke to his attorney and felt he was within his rights to decline a return to full duty. He hasn't worked since that time.

Since that time he has continued to treat with Dr. Hays and Dr. Gornet, which includes medications and a home exercise program, while Dr. Gornet has maintained him on work restrictions. Petitioner testified that he wants to have the recommended surgery.

Petitioner was seen at WorkCare, the occupational medicine clinic, on 10/27/14. Petitioner complained of pain from his shoulder blades down to his low back. He denied any history of depression, drug dependence, panic, or stress on this date. His current medications included Percocet, Norco, Prednisone, and Flexeril, as well as Celexa, which is an antidepressant. On physical exam, Petitioner was noted to have pain on motion, pain on palpation, and spasm over the lumbar and thoracic spines. No neurological exams were documented. Petitioner was diagnosed with lumbar and thoracic strains and referred for MRIs of his lumbar and thoracic spines. He also was given light duty work restrictions. (Rx24).

The 10/27/14 lumbar MRI impression was minor degenerative disc disease and minimal/mild facet arthropathy similar to that seen on a July 2013 lumbar MRI. The findings included a small disc bulge and minor facet arthropathy at L4-5 causing mild central canal and bilateral foraminal stenosis, as well as a minimal concentric disc bulge with right paracentral annular fissure at L5-S1 that did not displace the S1 nerve root. The thoracic MRI from the same date indicated facet arthropathy that was minimal at T9-10 and mild at T10-11. A minimal posterior disc bulge was present at T11-12 that did not cause central canal or foraminal stenosis. The remaining levels were normal. (Px16).

On 11/3/14, WorkCare noted no anatomically specific subjective complaints. Petitioner's physical exam results and diagnoses were unchanged from the prior visit and he was referred for physical therapy. (Rx25).

On 11/4/14, approximately two weeks following the second accident, Petitioner was seen by Dr. Hays. Petitioner gave a history of having recently reinjured his back while trying to hold a patient. Dr. Hays documented the following regarding Petitioner's subjective complaints: "His pain level is about the same as it was prior to the first injury he is limited in what he can do as far as his daily activities." (Rx27). At trial, Petitioner testified he trusted that Dr. Hays accurately documented what he told him. Dr. Hays' note indicated he knew Petitioner personally, "as my wife is related to his wife," and had observed him at family functions. (Rx27).

On 11/5/14, Petitioner underwent a physical therapy evaluation at SIH Logan Park Rehab. Petitioner reported he fell on a wet floor in July of 2013, and had been through two rounds of PT. He also gave a history of assisting a patient on 10/22/14, which "knotted him up from shoulder blade down." He reported he was already seeing a surgeon who had offered surgery. He stated he had tingling down both legs to his toes. On exam, sensation was intact bilaterally. Lying straight leg raise testing was positive bilaterally. The plan was therapy twice a week for six weeks. (Rx25).

On 11/17/14, Petitioner returned to WorkCare. Petitioner stated most of his pain was in the lumbar region but it radiated up to his mid thoracic region. He described his lumbar pain as unbearable, and his thoracic symptoms to be moderate. He reported physical therapy had not helped. On exam, Petitioner had pain to palpation and motion over the lumbar and mid thoracic spines, with limited range of motion. There was no decreased sensation noted on exam. Petitioner's diagnoses remained unchanged and continued therapy was recommended. (Rx24).

On 12/3/14, a note from Logan Park Rehab indicated Petitioner reported ongoing pain and no improvement with aquatic therapy. After 9 sessions he was discharged from therapy with "max improvement attained." (Rx25).

On 12/8/14, Petitioner reported to WorkCare that he had low back pain and that his right leg was "giving out." There were no complaints documented concerning the mid thoracic area. On exam, heel and toe walking were able to be performed, otherwise the exam findings were unchanged from the prior visit, with no neurological exam documented. His diagnoses remained unchanged and Petitioner was referred to Dr. Jones. (Rx24)

On 12/12/14, Dr. Hays evaluated Petitioner for an unrelated cardiac condition, and nothing was indicated with regard to the back. (Rx27).

On 1/6/15, Petitioner returned to WorkCare with ongoing complaints of low back pain with no improvement, as well as tingling in both lower extremities. Petitioner's physical exam showed limited range of motion, and pain to palpation over both the lumbar and mid thoracic spines. Petitioner was referred to Dr. Gornet. (Rx24).

On 1/8/15, Dr. Hays noted Petitioner reported some discomfort from prolonged sitting at work, and that he had tenderness and some limitation of motion on physical exam, but no major deficits of coordination or sensation on neurological exam. On 2/3/15, Dr. Dr. Hays noted Petitioner's activity level was limited by back pain. Examination was the same as 1/8/15. Prednisone was prescribed. (Px16).

Also on 2/3/15, Petitioner reported 5 out of 10 low back pain into both legs with paresthesias to WorkCare. Petitioner indicated he had previously been referred to Dr. Gornet in 2013, and that Dr. Gornet wanted to perform a disc replacement and fusion at that time, however workers' compensation did not approve the surgery

and "he remains basically in limbo with no improvement at all." On exam, Petitioner had a positive straight leg raise test on the left. On 3/6/15, WorkCare noted 3/10 pain with moderate lumbar, bilateral leg, and thoracic pain. He was referred to Rehab Unlimited for a functional capacity evaluation. (Rx24).

On 3/9/15, SIH Rehab Unlimited noted Petitioner's chief complaint was low back pain with bilateral radicular symptoms with an onset date of 7/1/13, when he slipped and fell at work, though he also reported a "subsequent incident" in October of 2014 with exacerbation of his low back pain. A functional test was recommended. (Rx25).

On 3/13/15, Petitioner returned to WorkCare with unchanged subjective complaints and physical examination. Petitioner's work restrictions were decreased, and he was allowed to lift, push, and pull greater weight. He was referred for physical/occupational therapy. (Rx24).

On 3/19/15, Dr. Hays documented chronic pain in the mid and lower back, radiating down both legs at times. Petitioner denied any loss of sensation or motor strength, and on physical exam, Dr. Hays noted some tenderness and some limitation of motion, but noted no major deficits of coordination or sensation on neurological exam. (Px16).

On 3/25/15 Petitioner underwent an FCE which demonstrated ability to perform 71.9% of the physical demands of his job. He was able to lift 25 pounds, carry 21 pounds, and push/pull 50 pounds. Work conditioning was recommended, and Petitioner underwent same from 3/26 to 4/13/15. (Rx25). On 3/30/15, Petitioner returned to WorkCare describing lumbar pain shooting down his right lower extremity, as well as loss of range of motion in the lumbar spine. The note indicated that symptom magnification was present and described Petitioner's attitude and effort as "fair." (Rx24).

A 4/7/15 FCE showed Petitioner was capable of performing 81.9% of the physical demands of his job. (Rx25).

On 4/13/15, at WorkCare, Petitioner reported 8/10 lumbar pain, with "unrelenting" lumbar, thoracic, and lower extremity pain. Symptom magnification was again noted, Petitioner's attitude was "poor," and his effort was "fair." (Rx24).

On 4/14/15, the physical therapist noted Petitioner had been having issues with muscle spasms. His gait was noted to be slowed, stiff, and guarded. He was forward flexed at the hip. He demonstrated stiff, guarded, and abnormal mechanics on transfers. None of his therapy goals were noted to have been met. Petitioner continued with work conditioning on April 20, 22, 23, 27, and 29, 2015. (Rx25).

On 4/27/15, Petitioner reported spasms in his lower back, in addition to pain radiating down both legs. On physical exam, Dr. Hays noted some tenderness and some limitation of motion. (Px16). Petitioner still had not met any of his physical therapy goals as of 4/30/15, and work conditioning continued through 6/3/15. (Rx25).

On 5/1/15, Petitioner returned to WorkCare. Petitioner reported 7/10 pain in his lumbar and thoracic spines. He again described unrelenting lumbar pain, and his thoracic pain was moderate. No neurological findings were documented on exam. The note documented a decrease in Petitioner's lifting status on his most recent functional progress note from physical therapy. (Rx24).

On 5/28/15, Dr. Hays indicated Petitioner reported he was undergoing physical therapy without progress or success. Petitioner denied any loss of sensation or motor strength, and on physical exam, Dr. Hays noted some tenderness and some limitation of motion, but no major deficits of coordination or sensation on neurological

exam. Dr. Hays wrote three prescriptions for Norco, each consisting of 120 tablets, and each able to be filled at different time intervals, as well as Flexeril. (Px16). On 5/29/15, Petitioner again reported unrelenting pain to WorkCare. (Rx24).

On 6/8/15, Petitioner saw orthopedic surgeon Dr. Gornet for the first time following the second accident. Dr. Gornet documented a prior history of a work accident on 7/1/13, and Petitioner's subsequent return to work in September of 2014. Petitioner reported he was subsequently involved in a second accident in October 2014, at which time he had increasing pain and symptoms, including up his thoracic spine. Dr. Gornet did not document any physical exam. His reported stated the following: "He did not feel it changed his symptoms significantly. He denies any new neurologic issues with his legs. He continues to still have low back pain, buttock and leg symptoms, particularly on the right side." When compared to Petitioner's 2013 films, Dr. Gornet noted Petitioner's October 2014 MRI still showed the central disc herniation at L4-5 and a central disc herniation/annular tear at L5-S1. Dr. Gornet stated the second accident aggravated Petitioner's underlying condition, changing his symptoms "to some extent", but his working diagnosis remained the same: discogenic pain at L5-S1 and a central disc herniation at L4-5. Dr. Gornet increased Petitioner's lifting restriction from 10 pounds to 25 pounds. Dr. Gornet stated his original recommendation for a fusion at L5-S1 and disc replacement at L4-5 was still appropriate. (Px13).

On 6/9/15, Rehab Unlimited noted that Petitioner was overall benefitting from work conditioning with slow improvement. However, he was discharged from work conditioning on that date per Dr. Gornet and his surgical recommendation. (Rx25).

On 6/19/15, Petitioner described a new complaint of a sharp ache radiating down the left lower extremity at WorkCare. The physical exam was noted to be limited due to Petitioner's complaints of pain, and symptom magnification was again noted. (Rx24).

On 6/24/15, Dr. Hays documented chronic back pain. On physical exam, he noted some tenderness and some limitation of motion, but no major deficits of coordination or sensation on neurological exam. This visit appears to have been mainly regarding a right wrist condition. On 7/23/15, Petitioner reported a recent increase in symptoms of numbness down the right leg which was not present a few months prior. (Px16).

At WorkCare on 7/31/15, Petitioner reported the same subjective complaints as in prior visits, rating his pain at 7/10. Straight leg testing was noted to be positive bilaterally, however McGee's crossed straight leg raising testing was negative. (Rx24). On 8/20/15, Petitioner returned to Dr. Hays and reported an inability to sit for prolonged periods without having numbness in both lower extremities. Physical therapy was reportedly not helpful, and physical exam was unchanged from the previous visit. (Px16).

On 8/25/15, Petitioner returned to Dr. Gornet. His report did not document Petitioner's complaints or exam findings, but rather criticized Dr. Zelby's causation and treatment opinions as they related to the first accident. He disagreed with Dr. Zelby's findings that Petitioner showed signs of symptom magnification, that Petitioner was at maximum medical improvement as it related to his first accident, and that Petitioner did not require surgical intervention. (Px13).

On 8/27/15, Petitioner returned to WorkCare. He described lumbar, lower extremity, and thoracic complaints. The note indicated that no special tests were able to be performed on exam due to Petitioner's pain. (Rx24).

On 9/16/15, Petitioner returned to Dr. Hays. The note described chronic back pain since the first accident, but made no mention of the second accident. Dr. Hays documented no change in Petitioner's physical exam, which

documented only some tenderness and some limitation of motion, but no sensation deficits. Petitioner's Norco prescription was refilled. (Px16).

Petitioner was examined by Dr. Zelby on 9/21/15 at the request of the Respondent. Following the second accident, Petitioner reported to Dr. Zelby complaints of pain around the level of the shoulder blades down to the hips in the middle, and down both sides of the back. Petitioner's reported pain around the upper buttocks, worse on the right, soreness just below both shoulder blades, and numbness circumferentially in both lower extremities, both worst and constantly in his feet. Dr. Zelby performed detailed physical and neurological examinations of Petitioner, which were both normal. Dr. Zelby documented inconsistent behavioral responses, such as positive responses for pain on superficial light tough, pain on simulation, diminished pain on distraction, and non-anatomic sensory changes in the entire right lower extremity. Petitioner's response to a lying straight leg raise test was positive bilaterally, but his response to the same test sitting was negative bilaterally. Petitioner was positive for 4/5 Waddell signs with significant symptom amplification on exam. (Rx16).

Dr. Zelby reviewed Petitioner's 10/27/14 thoracic MRI, and stated it showed mild degenerative changes throughout, and chronic Schmorl's nodes in the mid-lower thoracic region, with no stenosis or impingement at any level. His review of the 10/27/14 lumbar MRI reportedly showed mild degenerative disc disease at L5-S1, more than L4-5, with modest loss of disc space height at L5-S1. There was broad based bulging at L4-5 or modest disc protrusion with mild effacement of the ventral CSF centrally. There was mild left greater than right lateral recess stenosis at that level. At L5-S1, there was a broad based bulging disc and a small paracentral right, partial thickness annular tear. There was no neural impingement at any level. When compared to the previous 7/25/13 MRI, Dr. Zelby noted mild progression of the degenerative changes consistent with the passage of time with no acute or post-traumatic abnormalities. Based on his exam of Petitioner, and his review of Petitioner's records and scans, Dr. Zelby concluded Petitioner's reported second accident did nothing to exacerbate, aggravate, or accelerate the mild degenerative condition in his lumbar spine. Even assuming Petitioner's L5-S1 annular tear was acute, Dr. Zelby stated that annular tears are a self-limiting condition that will heal over three to four months. Although Petitioner's L5-S1 annular tear remained radiographically apparent, it was not a source of Petitioner's pain in the context of his mild degenerative condition, and in no way was a basis to pursue a fusion at that level. (Rx16).

Dr. Zelby found Petitioner's subjective complaints to be inconsistent with the objective medical findings, and inconsistent with the natural history of Petitioner's objective medical condition. There was no medical basis to suggest Petitioner's ongoing complaints were causally related to either his mild degenerative condition in his spine or his purported work accidents. Dr. Zelby opined Petitioner's symptoms were related to symptom amplification, given his normal neurological exam, normal spine exam, and mild lumbar degeneration. He believed Petitioner had reached maximum medical improvement (MMI) relative to the second accident by February of 2015 at the latest, and was safely qualified to work without restrictions. There was no reasonable expectation that surgery would provide Petitioner with meaningful or sustained relief in the context of such mild degeneration. Petitioner required no further diagnostic studies or further treatment directed at his spine irrespective of cause. Dr. Zelby indicated that Dr. Gornet's persistent recommendations for surgical intervention were inconsistent with spine care necessary for Petitioner's condition, and were not in Petitioner's best interests or the long term health of his spine. (Rx16).

On 10/13/15, Petitioner returned to Dr. Hays. The note documented anatomically nonspecific subjective complaints of back pain, which were worse with activity, and which did not seem to be improving. Dr. Hays again wrote three months worth of Norco prescriptions. On 11/10/15, Dr. Hays noted nonspecific subjective complaints of slightly increased low back pain only, and physical exam was unchanged from the prior visit. (Px16).

On 11/30/15, Dr. Gornet noted a normal physical exam on this date was that it was normal. This was Dr. Gornet's first documented physical exam of Petitioner since the initial visit in 2013. Dr. Gornet did not describe any specific subjective complaints, stating only that Petitioner's symptoms "affect all aspects of his life and his quality of life." Dr. Gornet recommended a CT discogram at L3-4, L4-5, and L5-S1, a new MRI, and MRI spectroscopy. Dr. Gornet continued the same work restrictions for Petitioner. (Px13).

On 12/18/15, Petitioner returned to Dr. Hays. The note documented complaints of back pain radiating down both legs, which Petitioner described as slightly increased lately. Physical exam was unchanged, and Norco was again prescribed. (Px16 at 58-59).

On 12/28/15, Dr. Zelby rendered an impairment rating pursuant to the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition of 5% of the whole person. (Rx17).

On 1/18/16, Dr. Hays noted Petitioner reported that his daily activities were limited due to back pain, and that he stated he could not work for long periods of time or stand for prolong periods of time. His exam was unchanged from his prior visit, with an added subjective notation that Petitioner was more comfortable standing. (Px16).

Also on 1/18/16, Dr. Gornet's proposed surgical intervention was submitted to Dr. Treister for utilization review. Dr. Treister determined that the proposed surgery was not reasonable and necessary. He noted that Petitioner's records demonstrated widespread tenderness, no objective evidence of radiculopathy, and no evidence of relief with prior conservative care. Petitioner also appeared to be on significant quantities of narcotic medication with only limited relief of his symptoms. Dr. Treister further noted that ODG guidelines and other relevant orthopedic literature warn against surgeries on patients with Waddell findings, who are on significant doses of narcotics, and who suffer from depression. In any of those instances, the likelihood of reasonable surgical results is extremely small, but when taken together, there is a very strong evidence in this case that surgery should not be considered. (Rx19).

On 1/22/16, Petitioner returned to WorkCare reporting low back and lower extremity symptoms, with referral into the shoulder blades. Petitioner attributed his symptoms to the first accident, and stated the second accident exacerbated the symptoms. The recommendation was for work conditioning 50% of the time, and working within Petitioner's work restrictions for 50% of the time. (Rx24).

On 1/26/16, Petitioner underwent a work hardening/condition evaluation which showed he was able to perform 85% of the physical demands of his job. His complaints on this date were of aching pain localized in the lower thoracic and low back area. The 7/1/13 first accident was mentioned, but there was no mention of the second accident. On exam, Petitioner had positive bilateral straight leg raise tests, but otherwise a normal neurological exam. (Rx25). At trial, Petitioner testified he was treated by the physicians at WorkCare. He voluntarily agreed to participate in the work conditioning plan, but not the actual return to work portion of the plan. Petitioner testified that as part of the work condition plan, Respondent offered Petitioner light duty work, but he declined attempting it. Petitioner testified Respondent has a policy of accommodating all light duty work, and that he himself was accommodated by Respondent for several weeks. (Rx21).

Testimony was also offered at trial by Melanie Sanders, who is a nurse manager for Respondent and Petitioner's supervisor. Ms. Sanders confirmed Respondent has a policy of accommodating light duty work, that this policy applied to Petitioner, and that Petitioner's restrictions were accommodated. Ms. Sanders testified Respondent and Petitioner reached agreement that Petitioner would complete what she called a work ready program where Petitioner would spend part of his time with a therapist, and the other part of his time working modified duty.

As Petitioner's supervisor, Ms. Sanders testified that she presented Petitioner with the written agreement, and confirmed Petitioner refused to accept the work portion of the agreement. Petitioner continued with work conditioning on February 1, 2, and 5, 2016. (Rx25).

At WorkCare on 1/29/16, Petitioner was to be working 50% and participating in work hardening 50%. His subjective complaints consisted of tingling in the bottom of his feet and back of legs bilaterally, right greater than left. Physical exam was unchanged. Petitioner was to continue the work hardening program 50% of the time, and to continue working within his restrictions the other 50% of the time. (Rx24).

A 2/5/16 SIH Rehab Unlimited progress note documented Petitioner stating Dr. Gornet told him only surgery would fix him. The assessment stated Petitioner demonstrated an ability to return to work on a transitional/gradual return to full duties beginning at the functional levels outlined in the report for one week. Petitioner refused to participate in this transition. A functional progress note from that same date demonstrated Petitioner's ability to perform 86.1% of the physical demands of his job. Petitioner participated in work conditioning at SIH Rehab Unlimited on February 9 and 10, 2016, and underwent a 2/12/16 functional progress exam which documented his ability to perform 88.1% of the physical demands of his job. (Rx25).

On 2/12/16, Petitioner returned to WorkCare, stating Respondent would not allow him to work because his neurosurgeon didn't want him to. He was advised to continue with the 50% work hardening, 50% working with restrictions plan. On 2/19/16, Petitioner declined a physical exam, was noted to have completed work hardening and was discharged from care with an expectation that he would be at MMI in two months. He was released to regular duty work without restrictions as of this date. (Rx24). An FCE on this date indicated an ability to perform 86.4% of the physical demands of his job, however it was noted that Petitioner may have been limited due to a recent discogram. Petitioner was noted to have refused to perform certain portions of this exam. (Rx25).

At trial, Ms. Sanders testified that following Petitioner's full duty release, on or about 2/19/16, she texted Petitioner and asked when he would be available to sit down and look at a schedule. Petitioner replied he was not released from his surgeon and therefore would not be returning to work. Petitioner confirmed this work offer from Respondent in his testimony.

On 3/2/16, Petitioner returned to Dr. Hays. The note described chronic back issues with radicular pain down his right leg, with no mention of his left leg. Petitioner informed Dr. Hays that he had been trying to work, but had not been allowed to do so for the last six weeks because he refused to accept the workers' compensation physician's reports that he was uninjured. Petitioner also reported he tried physical therapy, but was having difficulty with the recumbent bike, stating that after five minutes his groin goes numb. His physical exam on this date showed some tenderness and some limitation of motion, but no major deficits of coordination or sensation. Petitioner was prescribed Ativan. (Px16).

On 3/9/16, Petitioner returned to Dr. Gornet, and he documented Petitioner as having undergone a CT discogram, however no record of a CT discogram was offered into evidence. According to Dr. Gornet, the CT discogram revealed "a provocative disc moderate to severe at L4-5 and severe at L5-S1." This note also implied Petitioner underwent an MRI spectroscopy, however no record of any MRI spectroscopy or the specific results was offered into evidence. According to Dr. Gornet, "the information from MRI spectroscopy correlates with the objective information on CT discogram." Dr. Gornet related Petitioner's symptoms at that time to his first accident of 7/1/13 only, with no mention of the second accident. He recommended the same surgical procedure as before. Dr. Gornet indicated Petitioner would require a new MRI prior to surgery. He noted Petitioner's exam and work status were unchanged. (Px13).

On 3/30/16, Dr. Hays noted Petitioner described a new subjective complaint of radiation down the lateral aspect of an undefined leg into his fifth toe, which Dr. Hays characterized as consistent with the L5 nerve root. His exam was unchanged from the prior visit. Dr. Hays again prescribed Norco. On 4/29/16, Petitioner returned to Dr. Hays, and Baclofen was prescribed. On 5/27/16, Petitioner continued to complain of low back pain radiating down his legs with numbness. No changes in his back examination were documented from his prior visit, and Dr. Hays again prescribed Baclofen. (Px16).

On 6/20/16, Dr. Gornet noted Petitioner's exam and work status were unchanged. He again recommended surgery, relating Petitioner's symptoms and need for treatment to his first accident only, with no mention of the second accident. Dr. Gornet again referenced MRI spectroscopy and discogram results as showing clear information that Petitioner's "disc pathology is symptomatic." Dr. Gornet recommended a stress test and a new MRI. (Px13).

On 6/27/16, Petitioner returned to Dr. Hays. No specific subjective complaints were documented, and the physical exam of Petitioner's back was unchanged from the prior visit. (Px16).

Petitioner returned to Dr. Gornet on 10/6/16, and he documented nonspecific low back pain, which he related to Petitioner's first accident only, with no reference to the second accident. Dr. Gornet also noted mid-back pain, which Dr. Gornet related to Petitioner's second accident. This was Dr. Gornet's first mention of subjective complaints of mid-back pain since June of 2015, when Dr. Gornet documented thoracic pain immediately following the second accident. Dr. Gornet's treatment recommendation was only directed at Petitioner's low back, and consisted of the same surgery recommended previously. His work status remained unchanged. (Px13).

On 10/12/16, Petitioner returned to Dr. Hays. Petitioner told Dr. Hays that he was not allowed to return to work for Respondent. The note stated Petitioner had been diagnosed with a herniated disc and right lumbar radiculitis. No specific subjective complaints were noted, and the physical exam was unchanged from the prior visit. (Px16).

Dr. Gornet was deposed for the second time on 10/19/15. He saw Petitioner for the first time following the second accident on 6/8/15. Following the second accident, Dr. Gornet's recommendation for an L4-5 disc replacement and L5-S1 fusion remained unchanged. At the time of Dr. Gornet's first deposition, Dr. Gornet had reviewed none of Petitioner's medical records other than those of Dr. Jones and an MRI. Dr. Gornet reviewed no other records following his first deposition other than Dr. Zelby's report and the lumbar MRI from October of 2014. (Px17).

On 11/25/13, Dr. Gornet's only documented physical findings were of mild decrease in EHL function and intermittent decrease in sensation in the L5 dermatome. His working diagnosis on that date was of a disc herniation and annular tear. No physical examination was documented on 6/8/15, and on 8/24/15 no subjective complaints or physical examination was documented. Dr. Gornet testified that Petitioner told him his symptoms were not changed significantly as a result of the second accident. He testified that his understanding was that the character and location of the symptoms had not changed. Petitioner still had structural back pain and still had symptoms of low back pain more to the right side, right buttock, and right posterior thigh. He testified: "The intensity may have obviously increased to some extent but our belief was that the location where it was was still essentially the same. The last visit I think he had symptoms of more bilateral nature. But for the most part, the character and how the symptoms affected his life had not changed." (Px17)

Dr. Gornet testified that whether someone "aggravates" an underlying condition is based on the subjective complaints and whether the medical records support that and how it impacts their life. He saw no meaningful change between Petitioner's first lumbar MRI and his October 2014 MRI. Dr. Gornet opined that Petitioner has a central disc herniation at L4-5, and an annular tear at L5-S1. Dr. Gornet agreed that a disc herniation can be asymptomatic, and that a disc herniation identified on an MRI does not necessarily mean that it requires treatment. The same is true of annular tears, which is why surgeons do not simply operate based on MRI findings. (Px17).

Dr. Gornet has proposed a two-level surgery, including the use of a ProDisc-L disc replacement system at L4-5. The ProDisc-L has been released by the FDA for treatment of one symptomatic level of degenerative disc disease only. The criteria for use of the ProDisc-L includes six months of failed conservative treatment, and Dr. Gornet believed that as of the first time he saw Petitioner, he had gone over six months with conservative treatment, consisting of physical therapy and an injection, and remained symptomatic. (Px17).

Board certified neurosurgeon, Dr. Zelby, testified via deposition on 2/1/16. He had previously examined Petitioner at the Respondent's request. At that time, Dr. Gornet had proposed a two-level surgery consisting of a fusion at L5-S1 and a disc replacement at L4-5, which Dr. Zelby did not agree with. Such a surgery in the context of Petitioner's mild spinal degeneration exceeded the guidelines for treatment based on an objective medical condition. There was no medical indication to suggest or pursue such a surgery because there was no reasonable expectation that it would provide Petitioner meaningful or sustained relief of his symptoms. His testimony was that Dr. Gornet's proposed use of the disc replacement system was not FDA approved. (Rx18).

Dr. Zelby examined Petitioner for the second time on 9/21/15. Petitioner reported he returned to work full duty in September of 2014, and sustained a second accident in October 2014. His subjective complaints were around the upper buttocks, worse on the right than the left, as well as soreness just below the shoulder blades. He also reported numbness circumferentially in both lower extremities, worst and constantly in his feet. He rated his pain at 6 to 9/10, but Dr. Zelby testified Petitioner's 9/21/15 presentation was not consistent with pain at that level. On exam, Petitioner's thoracic and lumbar spines appeared normal. He reported tenderness in the lower and upper gluteal regions, more on the right, even with non-physiologic light touch, which Dr. Zelby identified as a Waddell sign, as a report of severe pain with light tapping on the skin should not elicit pain regardless of a spinal pathology. During the exam, Petitioner reported a loss of sensation to both pin and vibration in the entire right lower extremity, which Dr. Zelby also identified as a Waddell finding and inconsistent with any condition in the spine or the nervous system. Petitioner also reported pain on simulation, meaning on exam Dr. Zelby simulated a load on the spine, but actually loaded the hips, yet Petitioner reported severe back pain. Petitioner had diminished pain on distraction during his exam. He reported pain in his back with straight leg raise lying down, but no pain with straight leg raise sitting up, with Dr. Zelby indicating that these tests should elicit the same responses. (Rx18).

Dr. Zelby testified Petitioner's subjective complaints were not consistent with any objective pathology observed on Petitioner's lumbar MRI. The persistence and severity of Petitioner's subjective symptoms was inconsistent with the objective medical findings, and inconsistent with the natural history of his objective medical condition. Dr. Zelby testified that Petitioner had mild degeneration without neural impingement, a normal spine exam, a normal neurological exam, but tremendous complaints of pain, which just did not fit. Petitioner's symptoms specifically did not correlate to an annular tear at L5-S1. Dr. Zelby opined that this annular tear was more likely than not degenerative, but even if it were acute, he opined that all of the factors that lead to pain from an acute annular tear subside within three or four months. Annular tears are self-limiting problems, and not conditions which require surgical intervention. Petitioner's L5-S1 annular tear was present on his 2013 lumbar MRI, and thus was in no way caused by the second accident. (Rx18).

Dr. Zelby noted there was no physical exam or any subjective complaints noted in Dr. Gornet's 6/8/15 note correlating to any level of Petitioner's lumbar spine. His 8/24/15 note seemed more consistent with a narrative report, and it did not appear from the note that Dr. Gornet actually examined Petitioner on that date. Dr. Zelby noted nothing in records from Occupational Health Clinic or from Dr. Hays that correlated to symptomatic pathology present on either the lumbar or thoracic MRIs. Dr. Zelby opined Petitioner sustained a lumbar strain, in the context of mild degeneration that was fairly normal for Petitioner's age, as a result of the second accident. Dr. Zelby testified Petitioner had reached MMI long ago from this strain, and was able to return to his regular job without restrictions as of February of 2015 at the latest. Dr. Zelby did not causally relate Petitioner's ongoing subjective complaints to the second accident, or to any pathological condition in Petitioner's spine irrespective of cause. The proposed disc replacement and fusion was not reasonable and necessary treatment irrespective of cause, in Dr. Selby's opinion, and would not be in the best interests of Petitioner's long-term spinal health, as it would not be reasonable and necessary given all the attendant risks. He testified that the data on lumbar disc replacement is not great. Further, the procedure would change the biometrics of Petitioner's pine in a way that it does not need to be changed. (Rx18).

Dr. Zelby gave a 5% whole body impairment rating based on the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition. This impairment rating was based on Dr. Zelby's analysis of Petitioner's condition, and the related modifiers contained in the AMA Guides. (Px18).

Dr. Tresiter was deposed on 2/25/16. (Rx20). A board certified orthopedic surgeon, Dr. Treister performed utilization review on 1/18/16 with regard to the proposed two-level surgery proposed by Dr. Gornet, and determined that the surgery was not reasonable and necessary treatment of Petitioner's condition. (Rx20).

Dr. Treister previously performed a 12/13/13 utilization review for the same two-level lumbar surgery and testified he did not certify the procedure at that time either. Petitioner at that time was likely habituated to narcotics, which was a contraindication for surgery. There was no evidence of any specific focal nerve level of injury in terms of either subjective complaints, or more importantly, objective findings. Petitioner's conservative treatment was not classic conservative treatment for his issues. The proposed surgery was also experimental, and not approved by the FDA, as the disc replacement had been approved for use in single lumbar level, and not multiple level pathology cases. (Rx20).

Dr. Treister's review of Petitioner's post-December 2013 medical records did not change any of his opinions regarding the reasonableness and necessity of the recommended surgery. The proposed use of the ProDisc-L disc replacement is still not an FDA-approved use, as Dr. Gornet's proposed surgery constitutes treating two different levels of degenerative disc disease, which is not an FDA approved use of the device. Dr. Treister testified the package insert for the ProDisc-L from Synthes states the safety and effectiveness of the ProDisc-L has not been established in patients with more than one vertebral level of degenerative disc disease, which was why the FDA had not approved use of the device for a surgery involving more than one lumbar level. Petitioner has multiple levels of degenerative disc disease in his lumbar spine. (Rx20).

Dr. Treister testified Petitioner's medication regimen consisted of hydrocodone, oxycodone, and celexa, which is an antidepressant, among others. Under the ODG guidelines, surgical intervention is not recommended for patients who are habituated to narcotics because patients who have pain intolerance get very poor results from spinal surgery. The ODG guidelines also state that patients with psychological or psychiatric problems must be thoroughly evaluated in terms of presurgical consideration, as statistics show that patients who have psychiatric problems react very poorly to spinal surgical intervention. Dr. Treister could not identify a psychological evaluation in his review of the records which would support his candidacy for lumbar surgery in light of his

records of depression and use of antidepressants. Dr. Treister noted that Petitioner's initial treatment note following the second accident stated he was negative for any history of depression, which was a misrepresentation. (Rx20).

Dr. Treister testified that Petitioner's 10/27/14 lumbar MRI showed some disc space narrowing at L5-S1 with minimal osteophyte formation in the sacroiliac joint, and widespread, very mild degenerative changes in the lumbar spine. Dr. Treister testified that a reference to a 2 mm or 3 mm disc herniation indicates a very small disc protrusion. There was also fairly mild degenerative disc disease in the lower three thoracic levels. Petitioner's subjective complaints to WorkCare on 10/27/14 did not correlate to any pathology observed on either Petitioner's lumbar or thoracic MRIs. The physical findings were diffuse, widespread, and non-focal, and therefore also did not correlate to any pathology present at any level, specifically not to L4-5 or L5-S1. Dr. Treister testified the objective pathology does not cause pain and tenderness all over the spine. In Petitioner's case, there was widespread tenderness all over the lumbar spine in the absence of any bruising, abrasion, spasm, or any other similar finding, and this was potentially a Waddell sign. (Rx20).

Dr. Treister testified that Petitioner's subjective complaints of tingling down both legs to the toes and pain from the head to the lower back at therapy on 11/5/15 did not correlate to any condition of the lumbar or thoracic spines, including L4-5 or L5-S1. Any symptoms relative to pathology from L4-5 and/or L5-S1 have certain classic, specific patterns, and Petitioner's description of subjective complaints does not meet either of these patterns. (Rx20).

Dr. Treister testified that Petitioner had a history of prior injections which did not help with his pain at all. In patients who have objective spine pathology, if corticosteroids are injected into that area, it usually calms the inflammation down around the nerve and gives some relief for a period of time. If a patient reports no relief at all, it speaks against there being any significant, objective, legitimate pathology causing pain, and in his opinion points more towards psychological and functional problems. Dr. Treister reviewed Dr. Gornet's 6/8/15 note indicating the second accident of October 2014 did not significantly change Petitioner's symptoms, and did not reflect any physical exam, only a recommendation based on an MRI. This visit took place almost two years after Petitioner's prior visit to Dr. Gornet. He noted Dr. Gornet also did not document any physical exam on 8/24/15. Dr. Treister testified that a surgeon recommending surgical intervention of the spine must document physical findings, even if they are normal, as each exam involves documenting whether there has been any change from the previous exams to see if the neurological condition has gotten worse, remained the same, or improved. Dr. Trestier testified there is no evidence in Dr. Gornet's records supporting the reasonableness and necessity of any surgical intervention, even one less invasive than his proposed surgical intervention. (Rx20).

In Dr. Treister's opinion, Dr. Zelby's documented physical examination included a classic, thorough neuromuscular lumbar exam, documenting all of its components. He noted that Dr. Zelby found Petitioner had multiple Waddell signs, including circumferential numbness in both lower extremities and loss of sensation and pain on light touch, and that these are not an indication of objective pathology. Dr. Zelby documented no substantive neurological deficit on exam. (Rx20).

Dr. Treister found no evidence in the records and diagnostic scans of any sort of structural issues in Petitioner's lumbar spine that would require surgical intervention. While it was possible that Petitioner could be suffering from some lumbar and thoracic pain due to degenerative disc disease, Dr. Treister testified that the degenerative disc disease was very mild, and that there were no focal findings leading to radicular pain or neurological deficit. Dr. Treister testified Petitioner met none of the indications for spinal surgery under either the ODG guidelines or commonly accepted guidelines. He testified that he has personally performed spinal surgery for four decades, and that such surgery is not performed unless there is focal objective pathology that can

reasonably be assumed to be causing the symptoms. This determination must be made by a concurrence of the radiological findings, the subjective complaints, and the objective findings. He opined that a surgeon cannot make a surgical recommendation for a patient who presents with so called back pain with no classic radicular pattern and nothing focal on MRI. In this case, there was no concurrence of Petitioner's radiological findings, subjective complaints, and objective findings. (Rx20).

Dr. Treister described the ODG guidelines as a further refinement of commonly accepted practices. It is not appropriate to operate on patients who are habituated to narcotics, or on patients who have Waddell findings, or where the findings do not correlate, or where the patient had a response to conservative care. In addition to the surgery, Dr. Treister testified no additional diagnostic scans or procedures would be reasonable and necessary treatment for the same reasons. (Rx20).

CONCLUSIONS OF LAW

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

The Arbitrator finds that the 10/22/14 accident involved a very minor exacerbation of the Petitioner's subjective complaints, and did not cause any change in the Petitioner's preexisting condition. As such, the Arbitrator finds that the Petitioner's current condition is not causally related to the 10/22/14 accident.

The testimony of the Petitioner, Dr. Gornet, Dr. Zelby and Dr. Treister all support the determination that the event which occurred on 10/22/14 did not change the Petitioner's preexisting lumbar condition. This is further supported by the 10/27/14 lumbar MRI report which indicated no significant objective change in the lumbar condition, and the 11/4/14 report of Dr. Hays. .

Taking the totality of the evidence together, the Arbitrator believes that a strong preponderance of the evidence supports the finding that the Petitioner's lumbar condition is not causally related to the 10/22/14 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:

Based on the Arbitrator's findings regarding causation, this issue is moot.

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

Based on the Arbitrator's findings regarding causation, this issue is moot.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings regarding causation, this issue is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Georgine Bates,

Petitioner,

vs. NO: 15WC 26283

Chicago Park District,

Respondent.

18IWCC0146

DECISION AND OPINION ON REVIEW

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

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

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

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

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

DATED: MAR 12 2018
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MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BATES, GEORGINE
Employee/Petitioner

Case# **15WC026283**

CHICAGO PARK DISTRICT
Employer/Respondent

18IWCC0146

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

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

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

1946 CHICAGO PARK DIST LAW DEPT
LEON W PAWLYCOWYCZ
541 N FAIRBANKS CT 3RD FL
CHICAGO, IL 60611

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

GEORGINE BATES
Employee/Petitioner

v.

CHICAGO PARK DISTRICT
Employer/Respondent

Case # 15 WC 026283

Consolidated cases:

18IWCC0146

An *Application for Adjustment 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 **6/19/17**. 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 ____

18IWCC0146

FINDINGS

On **7/30/15**, 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 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 **$24,752.00** ; the average weekly wage was **$476.00**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **0** dependent children.

Because the Arbitrator finds Petitioner failed to prove accident, the remaining issues of causal connection, whether Petitioner has received all reasonable and necessary medical services, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, temporary total disability, nature and extent of the injury and Respondent credit are hereby rendered ***MOOT***.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**. Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove she sustained accidental injuries arising out of and in the course of her employment with Respondent on 7/30/15.

Because the Arbitrator finds Petitioner failed to prove accident, the remaining issues of causal connection, whether Petitioner has received all reasonable and necessary medical services, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, temporary total disability, nature and extent of the injury and Respondent credit are hereby rendered ***MOOT***.

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

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

Signature of Arbitrator

9-19-2017
Date

SEP 20 2017

FINDINGS OF FACT

Georgine Bates ("Petitioner") testified that she was employed as a Seasonal Attendant for Chicago Park District ("Respondent") on 7/30/15. Petitioner testified that she started her season in June of 2015.

On 7/30/15, Petitioner testified that she was taking a huge trash can down a ramp. Around 8:30pm, Petitioner testified that while walking down the ramp the trash can flipped over and that she the Petitioner fell to the ground. She stated the dumpster fell on her and that she injured her back trying to lift the dumpster off. She said she was injured due to both parts of falling down and lifting the can. There were no witnesses to the occurrence. Petitioner also testified that she reported the above incident to a Briana Rolland who was inside the Respondent's fieldhouse. Petitioner testified she was sent to Mercy Works by Respondent but never seen.

Petitioner testified that after attempting to be seen by Mercy Works, she then went on her own on that same date and presented to St. Mary of Nazareth Hospital for treatment of her lower back. Px1. Petitioner related she was injured at work the night prior while roling a plastic trash can weighing apprximatley 50 pounds down a ramp to the dumpster. She indicated the trash can fell and as she tried to pick it up, she started to feel pain in the left anterior rib area. Petitioner was diagnosed as having a muscle strain. *Id.* at 23. Another record listed sprain of ribs and other chest pain as final diagnosis. *Id.* at 15. Treatment consisted of medication. Petitioner was discharged by St. Mary of Nazareth Hospital to home/self care and advised to follow up with a primary doctor.

On 8/3/15, Petitioner saw Dr. Sajjad Murtaza from Illinois Orthopedic Network for her low back injury. Px2. She related that on 7/30/15 she was injured at work when a trahs can she was rollig fell over. While attempting to lift it, she felt pain in her left ribcage and low back. She complained of 7 out of 10 pain. Dr. Murtaza diagnosed thoracic/lumbar sprain injury. Treatment consisted of medication. Dr. Murtaza scheduled the Petitioner for re-evaluated one week later. Dr. Murtaza would consider physical therapy for Petitioner. Records do not show Petitioner returned to Dr. Murtaza.

Over 3 months later, on 11/17/15, Dr. Murtaza prescribed physical therapy for the Petitioner. Px3. On 12/3/15, Petitioner commenced physical therapy at ATI Physical Therapy. Petitioner attended physical therapy on 12/21/15, 12/22/15 and 12/30/15. On 1/3/16, Petitioner requested and was discharged from physical therapy. Petitioner cancelled 8 appiotnments for therapy. Px3, Rx1.

After treatment Petitioner returned to full duty elsewhere. Petitioner testified that on 5/20/17, she re-injured her lower back in an automobile accident. Petitioner testified that she is currently being treated for this low back injury. As of the date of trial, Petitioner testified she continues to experience a lot of back pain in the middle and lower back. She said her pain comes and goes. She expressed difficulty with sitting, walking, standing and running. Climbing stairs sometimes hurt her.

Stanley Rankin, a Seasonal Attendant for the Respondent, testified that he was employed by the District on July 30, 2015. Mr. Rankin testified that on the above date he worked with the Petitioner. Mr. Rankin testified that on the evening of 7/30/15, he observed the Petitioner rolling a trash can down a ramp. Mr. Rankin

further testified that the trash can got out of Petitioner's hands and that it rolled down the ramp and flipped over. Mr. Rankin testified that Petitioner did not fall when the above occurrence took place. Mr. Rankin also testified that he did not see Petitioner fall down trying to prevent the trash can from falling. Mr. Rankin testified that there was nothing heavy in the trash can. Mr. Rankin further testified that he helped Petitioner pick up the stuff that spilled out of the can. Mr. Rankin also testified that Petitioner didn't lift the trash can. Mr. Rankin testified that he lifted the trash can himself. Mr. Rankin also testified that Petitioner never came back to work after the above incident. Petitioner testified that Mr. Rankin was not there at the time of the above occurrence on 7/30/15.

CONCLUSIONS OF LAW

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

Having carefully considered all evidence, the Arbitrator concludes that Petitioner failed to prove she sustained accidential injuries arising out of and in the course of her employment on 7/30/15 with Respondent. In so finding, the Arbitrator notes that Petitioner lacked credibility both at trial and at various times throughout the time in which she attempted to seek treatment for her alleged accident. For instance, Petitioner initially testified that she injured herself when the trash can fell and she got stuck under it but later testified that she injured herself from both the falling can and while trying to lifting the can. The mechanism of injury as testified to not only conflicts but is not corroborated by any medical record. Petitioner also testified that she saw Dr. Murtaza numerous times yet the record shows only one visit with Dr. Murtaza on 8/3/15. Petitioner likewise testified that she attended physical therapy "numerous" times and that she started therapy before 12/3/15. However, the record shows Petitioner cancelled 8 therapy appointments and attended only 4. Dr. Murtaza wrote a prescription for physical therapy but there is no record of the doctor having seen Petitioner at that time. In addition, Petitioner's medical record reflects a treatment gap of over 3 months that Petitioner simply could not recall nor for which any reasonable explanation was given. Given the foregoing, the Arbitrator finds Petitioner lacked credibility as to the history of accident and course of treatment.

The Arbitrator finds the testimony of Respondent's witness, Mr. Stanley Rankin, more credible than that of the Petitioner. At Arbitration Mr. Rankin testified that he worked for the Respondent on July 30, 2015. Mr. Rankin testified that on the evening of July 30, 2015 he observed the Petitioner rolling a trash can down a ramp. He further testified that the trash can got out of Petitioner's hands and that it rolled down the ramp and flipped over. Mr. Rankin further testified that the Petitioner did not fall when the above event took place. Mr. Rankin also testified that he did not see Petitioner fall down trying to prevent the trash can from falling. Mr. Rankin further testified that Petitioner didn't lift the trash can. Mr. Rankin testified that he lifted the trash can himself.

Based upon the above the Arbitrator finds that Petitioner's alleged injury of July 30, 2015 was not an accident that arose out of and in the course of Petitioner's employment by Respondent. Because the Arbitrator finds Petitioner failed to prove accident, the remaining issues of causal connection, whether Petitioner has received all reasonable and necessary medical services, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, temporary total disability, nature and extent of the injury and Respondent credit are hereby rendered ***MOOT***.

Signature of Arbitrator

9-19-2017
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sylvia Mendez,

Petitioner,

vs. NO: 11WC 0929

Monterey Mushroom,

18IWCC0147

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 1, 2017, is hereby affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that commencing September 23, 2014, Respondent pay to Petitioner the sum of $461.78 per week for life under §8(f) of the Act for the reason that the injuries sustained caused the total permanent disability of Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that 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.

18IWCC0147

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $43,000.00. 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: MAR 12 2018
o030618
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MENDEZ, SYLVIA
Employee/Petitioner

Case# **11WC000929**

MONTEREY MUSHROOM
Employer/Respondent

18IWCC0147

On 2/1/2017, 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 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1097 SCHWEICKERT & GANASSIN LLP
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

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

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sylvia Mendez
Employee/Petitioner

v.

Monterey Mushroom
Employer/Respondent

Case # **11** WC **0929**

Consolidated cases: _____

18IWCC0147

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine M. Ory**, Arbitrator of the Commission, in the city of **New Lenox** on **May 10, 2016** and **Ottawa** on **June 22, 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 What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. X What is the nature and extent of the injury?
M. X Should penalties or fees be imposed upon Respondent?
N. X Is Respondent due any credit?
O. X Other **Permanent Total Disability**

FINDINGS

On **October 11, 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 **$27,875.12**; the average weekly wage was **$536.06**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **2** dependent children.

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

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

To date, Respondent has paid **$29,669.83** in TTD and/or for maintenance benefits (subsequent to the first hearing on March 28, 2012), and is entitled to a credit for any and all amounts paid.

Respondent shall be given a credit of **$29,669.83** for TTD, **$0** for TPD, **$0** for maintenance, and **$4,824.60** for other benefits, for a total credit of **$34,494.43.**

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

ORDER

Medical Benefits

Respondent shall pay the bills totaling **$1,176.84**, subject to the fee schedule and pursuant to §8 and §8.2 and subject to credit for any payments made by respondent for the claimed bills.

Temporary Total Disability

Respondent shall pay TTD from **March 29, 2012 through September 22, 2014, or weeks 129-5/7 weeks @ $357.37 per week.**

Permanent Disability

Respondent shall pay **Permanent Total Disability benefits in accordance with §8(f) as of September 23, 2014 at the minimum rate of $461.78 per week.**

Penalties and Attorneys' Fees

Respondent shall pay **penalties of $21,144.54 pursuant to §19 k and attorneys' fees of $8,457.81 under §16** as respondent's failure to pay temporary total disability was unjustified, unreasonable and vexatious.

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

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

Christine M Ong — 1/25/2017

Signature of Arbitrator — Date

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sylvia Mendez,	)	
Petitioner,	)	
vs.	)	**No. 11 WC 00929**
Monterey Mushrooms	)	**18IWCC014**
Respondent.	)	
	)	

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in New Lenox on May 10, 2016 and in Ottawa on June 22, 2016. This matter had previously been heard on March 28, 2012 pursuant to Section 19 b/8a of the Act. The parties stipulated petitioner sustained accidental injuries from an accident occurring on October 11, 2009 that arose out of and in the course of her employment with respondent and that petitioner's earnings in the year pre-dating the accident was $27,875.12 and her average weekly wage was $536.08.

The Commission determined: petitioner's back condition was caused by the work accident of October 11, 2008; petitioner was entitled to temporary total disability from January 24, 2011 through March 28, 2012; petitioner was entitled to payment of certain medical bills; and was entitled to prospective medical treatment, including a spinal fusion.

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 additional temporary total disability.
4. Whether petitioner is entitled to Attorneys' fees and penalties.
5. What is the nature and extent of petitioner's injury/whether petitioner is permanently and totally disabled?
6. What credit is due respondent?

FINDING OF FACTS

The Petitioner does not speak English; her native language is Spanish. She testified with the assistance of Miguel Arteaga, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Mr. Arteaga served as an interpreter for the Petitioner.

Since the last hearing on March 28, 2012, petitioner continued to have complaints of pain. She did not seek medical treatment after the last hearing until June 22, 2014, which was at Illinois Valley Community Hospital in the form of an MRI and X-ray. (Although the records of Dr. DePhillips indicate petitioner actually saw Dr. DePhillips on May 22, 2012 and June 12, 2012. These records also indicate she underwent an MRI on May 29, 2012 and may have had a discogram at that time.) (PX.2)

She saw Dr. DePhillips on July 24, 2014 in Indiana. In the gap period of treatment, she received Norco for pain. At the time of her visit with Dr. DePhillips on July 24, 2014 petitioner noticed pain in her lower back running down her left leg. Dr. DePhillips continued to recommend surgery. She was depressed. Petitioner's personal physician, Dr. Bernal prescribed medication for depression.

Petitioner remained off work from the date of the last hearing through July 24, 2014. Dr. DePhillips provided an off work slip on July 24, 2014.

On August 7, 2014, petitioner returned to Dr. DePhillips. She had pain down both legs. Dr. DePhillips again provided an off work slip. It was at this visit that Dr. DePhillips decided that due to the length of time, petitioner would no longer benefit from surgery. In September, 2014, Dr. DePhillips determined petitioner was permanently and totally disabled.

Petitioner has seen her family doctor, Dr. Bernal, from time to time for pain medication. Dr. Bernal prescribed Norco for pain until it affected petitioner's digestive system. She now takes only over-the-counter pain meds. She has applied for social security disability; the decision is pending.

Prior to her injury, she performed all activities of daily living, including preparing meals, walking with kids to park, cleaning clothes, vacuuming, sweeping and grocery shopping. She no longer is able to perform these tasks.

Petitioner was seen again by Dr. Salehi at respondent's request on November 4, 2014. Petitioner disagreed with Dr. Salehi's indication that he had performed an examination of petitioner; as he did not. Dr. Salehi asked her to point where it hurts and lay down, but did not touch petitioner. Petitioner testified she was not able to lay flat on her back as requested by Dr. Salehi. Petitioner has not been able to work since the November 4, 2014 Dr. Salehi exam. Since petitioner was examined by Dr. Salehi, she has not been offered a position with respondent.

Petitioner agreed she was required to lift hangers, cans, baskets and other things weighing up to 20 pounds as described in respondent's job description (RX.3). The beds were approximately one foot by one foot and stacked from floor up the ceiling. As a picker, petitioner was required to travel up the side of the beds, picking mushrooms and then climb down carrying the filled baskets, two at a time. Petitioner estimated she did this fifty times a day. Petitioner estimated the baskets and materials she was required to carry could weigh as much as thirty pounds. Petitioner has not been offered a position and she has not returned to work for respondent.

Petitioner was examined by Dr. Robert Eilers in August, 2015 at request of her attorney. Petitioner was not aware Dr. Eilers testified petitioner could do sedentary work.

Carolyn Fettik testified in behalf of respondent. She had been employed by respondent for thirty years. She is now a harvesting, or picking, supervisor; a position she has held for eight years. She trains the pickers and works alongside pickers when she has time available.

Fettik testified the job as a picker required the picker to climb the side of the mushroom bed with a lug and a stump bucket. The lug holds four square baskets that weight approximately eight pounds when empty. The stump bucket hooks onto to the picking lug. The lug weighs approximately twenty pounds when filled. The stump bucket weighs approximately seven to eight pounds when filled. A picker scales the side of the beds with use of the ladder rack, moving the stump bucket and lug at each level, starting at floor level and works his or her way up the beds which are ten feet high. The most a picker is required to carry/lift would be twenty pounds.

On cross examination, Fettik testified pickers are paid according to the mushrooms he or she harvested. Fettik agreed the lug weighed twenty pounds when full; the stump bucket weighed eight pounds when full; the ladder weighs one pound. Due to the physical nature of the job, a

picker was required to have mobility, agility and general good health. It could not be performed by a person using a cane. Pickers are not required to carry the full lug.

St. Margaret's Health System/Dr. Alejandro Bernal Records (PX.1)

These records reflect petitioner was seen by Dr. Bernal on March 17, 2015 due to anxiety, back and neck pain. Petitioner advised she had taken Norco up until 2014, which had helped with her pain. Dr. Bernal prescribed Ibuprofen/Famotidine (Duesix) and renewed the Norco.

North Central Neurosurgery/Dr. George DePhillips (PX.2)

Petitioner returned to Dr. George DePhillips on May 22, 2012. She reported her pain in her lower back that radiated down he thigh and medial shin to her ankle was getting progressively worse. Dr. DePhillips recommended a repeat MRI. Dr. DePhillips discussed the possibility of a lumbar fusion.

On June 12, 2012 petitioner returned to Dr. DePhillips after obtaining an MRI on May 29, 2012. Dr. DePhillips believed a two level fusion at the L3-4 and L4-5 level were in order. Dr. DePhillips was awaiting Dr. Malek's final report of the discogram before making any further recommendations.

The next portion of these records include a report of petitioner's visit to Dr. DePhillips on August 14, 2014. Dr. DePhillips noted that the provocative portion of the discogram, which had been done the day before by Dr. Grewal, showed concordant pain only at L5-S1 or L6-S1 level. Dr. DePhillips noted the earlier discogram showed concordant pain at L2-L3 and L3-4 level. In light of the difference in the recent discogram, Dr. DePhillips recommended a fusion at the L5-S1 level only.

At petitioner's September 22, 2014 visit with him, Dr. DePhillips concluded, based upon the recent radiographic imaging, that the risks of surgery outweighed the benefits petitioner would receive. Also on September 22, 2014, Dr. DePhillips also concluded petitioner was permanently and totally disabled as a result of her work injury.

Dr. Robert Eilers' October 21, 2015 Deposition & August 10, 2015 Report (PX.3 & PX.4))

Dr. Eilers testified via deposition for petitioner on October 21, 2015. Petitioner had examined petitioner on July 19, 2011 and again on August 10, 2015 (P.6). Dr. Eilers confirmed petitioner had injured her back when she fell to the floor landing on her back on October 11, 2009. At the time of her accident, she was pregnant, so some tests were delayed (P.7). A discogram was done on October 7, 2011 showing concordant pain at L3-L4 and L4-L5 level, with L3-L4 being primary location and L4-L5 being secondary (P.8).

At the time of Dr. Eilers' August 10, 2015 examination, petitioner had complaints of disrupted sleep, constant pain in her lower back that radiated into her legs (P.8). Dr. Eilers noted Dr. DePhillips had changed his mind about performing surgery after previously recommending, along with Dr. Malek, a fusion for petitioner. Dr. DePhillips did not rule out surgery in the future (P.9).

Dr. Eilers testified petitioner had problems with bending and lifting (P.10-11). Dr. Eilers' examination indicated petitioner's reflexes were normal; the straight leg raising on the right was positive at 75 to 80 degrees (P.11). Petitioner had problems forward flexing; only able to flex to 22 inches, which was four inches less than the previous exam (P.11). Petitioner had significant myofascial trigger points and a significant flattening of the lumbar lordosis or curvature (P.12).

Dr. Eilers reported petitioner's findings were consistent with multiple compression fractures at L1-L2 and an aggravation of her underlying degenerative disk diseases at L3 through L6 level, with severe myofascial pain in the lumbosacral paraspinals and SI joint involvement due to the fall, which has resulted in chronic pain causing limited mobility and dependency on narcotic analgesics (P.13-14).

Dr. Eilers confirmed the medical bills incurred were reasonable and appropriate to treat petitioner of her lower back injury (P.16). Dr. Eilers believe petitioner was competitive in a stable labor market (P.17). At most, Dr. Eilers believed petitioner would be capable of only a sedentary, part-time level of work; perhaps only an hour or so (P.16-17).

Dr. Eilers believed petitioner would need long-term pain management with narcotics and possible epidural injections (P.20-21). Dr. Eilers did not believe surgery would improve petitioner's employability (P.20).

On cross examination, Dr. Eilers did not place much weight on the FCA done at IVCH (P.21-22). Dr. Eilers confirmed he was not a vocational counselor, but based his opinion on petitioner's employability on the fact that petitioner was not capable of physically performing a job more for more than an hour or two and day, and some days not at all (P.23-24). At best, given her physical limitations, Dr. Eilers believed petitioner could only do piece work (P.24).

Dr. Eilers confirmed that as a board certified physician of physical medicine he makes his best effort to get patients back to competitive employment. In petitioner's case, he does not see this happening (P.26).

Dr. George DePhillips July 24, 2014 Report (PX.5)

Dr. DePhillips reported on petitioner's examination of July 24, 2014. Petitioner had ongoing pain in her buttocks that radiating down petitioner's legs and into the ankles; the right worse than the left. Dr. DePhillips recommended a repeat discogram before making a final surgery determination.

Medical Bills (PX.6)

Petitioner submitted various medical bills; the majority having been incurred prior to the first hearing on March 28, 2012. The only bills that can be considered, as they were incurred subsequent to the previous hearing, are:

$490.00 Dr. George DePhillips (05/22/2012-07/10/2012)
$64.00 Beacon Medical Group (08/07/2014)
$393.00 Hospital Radiology Service (06/02/2014)
$229.84 EQMD/Dr. George DePhillips (07/010/12)
$370.00 Community Health Clinic/Dr. Bernal (06/19/2015-08/11/2015)

Illinois Valley Community Hospital (IVCH) Records (PX.7).

These records contain a Lumbar Spine X-ray and MRI dated June 2, 2014. These studies show petitioner had mild neural foraminal encroachment at L4-5 and L5-6; most severe at L5-6.

Neurological Surgery & Spine Surgery/Dr. Sean Salehi November 4, 2014 Report (RX.1)

On November 4, 2014, petitioner was re-evaluated by Dr. Salehi on November 4, 2014. Dr. Salehi reported petitioner refused to perform lumbar range of motion or to lie flat. Dr. Salehi's conclusions on November 4, 2014 were the same he expressed in his report of July 12, 2011.

Dr. Sean Salehi's January 21, 2016 Deposition (RX.2)

Dr. Salehi reexamined petitioner on November 4, 2014 pursuant to §12 of the Act (P.6). He had examined petitioner in April and in July, 2011 (P.6). Petitioner advised Dr. Salehi that her complaints had remained the same since the previous exams (P.7). She was taking Norco for pain and was now depressed (P.7).

Dr. Salehi's reported his neurological exam revealed superficial tenderness, negative straight leg raising, positive sciatic notch tenderness on both sides. Petitioner's gait was a little slow, but normal. She had positive forward flexed posture. She had no spasms. Her strengths were normal in the lower extremities. She had decreased sensation in the right leg, but in a non-dermotal pattern. Her reflexes were normal. She had a few positive non-organic (Waddell's) signs. Petitioner refused to allow Dr. Salehi to test for lumbar ranted of motion of to lay flat. Dr. Salehi assumed it was due to petitioner's pain as to why petitioner would not allow Dr. Salehi to perform these two tests. (P.8-9).

Based upon petitioner's history and his examination, Dr. Salehi concluded petitioner had lower back pain syndrome, or chronic lower back pain (PX.10). It was Dr. Salehi's opinion that petitioner could return to work at her pre-injury level (P.11).

Dr. Salehi did not find any significant pathology that would cause petitioner to have a pain score of 10 out of 10 (P.12-13). Dr. Salehi believed petitioner was at maximum medical improvement (P.13). Dr. Salehi felt long-term use of narcotics, such as Norco, is inappropriate for long-term pain management (P.14-15).

Dr. Salehi disagreed with the Commission's determination that a two level fusion was warranted (P.19).

Respondent's Job Description/Analysis (RX.3).

Carolyn Fettik identified the exhibit as the job description of petitioner's position with respondent as a picker. Petitioner agreed with the description.

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:

In a previous decision, the Commission determined petitioner's low back pain/condition was caused by the work accident and surgery was reasonable and necessary to cure petitioner of her work injury. Petitioner was unable to obtain treatment subsequent to the March 28, 2012 until the case was finalized. The first time she saw a physician, after a final determination was made on the original hearing, was on July 24, 2014. Petitioner continued to have pain in her back that radiated down her legs. There is no indication there was any intervening accident since the original hearing. Nothing, other than time, has been given to petitioner to improve her back condition since it was determined by the Commission that she was entitled to treatment for her work injury.

Due to the delay in time, Dr. DePhillips elected not to proceed with surgery, as he was concerned that the risks would outweigh the benefits. However, he did not rule it out. The petitioner's condition remained the same. The Arbitrator therefore finds petitioner's continuing back condition was caused by the work accident.

The Arbitrator makes this finding despite the opinion of Dr. Salehi of November 4, 2014, that petitioner had no ongoing problems with her back. The Arbitrator notes this November 4, 2014 opinion of Dr. Salehi was this same opinion he had in July, 2011 that had been rejected by the Commission. Therefore, Dr. Salehi's opinion carries no weight in this present proceeding.

J. In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

The Arbitrator finds the evidence supports an award of for the following bills:
$490.00 Dr. George DePhillips (05/22/2012-07/10/2012)
$64.00 Beacon Medical Group (08/07/2014)
$393.00 Hospital Radiology Service (06/02/2014)
$229.84 EQMD/Dr. George DePhillips (07/010/12)

Although petitioner testified she was receiving prescription refills from her personal physician, Dr. Bernal, there were no records to support the bills from Dr. Bernal totaling $370.00 for the visits in 2015 were for treatment of the back injury. Therefore, these bills are denied.

L. In support of the Arbitrator's decision with regard to TTD, the Arbitrator finds the following:

Petitioner is entitled to temporary total disability (including the previous award) from January 24, 2011 to the date of September 22, 2014, which is the date Dr. DePhillips found petitioner was permanently and totally disabled. This is 191-1/7 weeks at the rate of $357.37 per week.

L. In support of the Arbitrator's decision with regard to the nature and extent of the injury, the Arbitrator finds the following:

Dr. DePhillips determined petitioner was medically permanently and totally disabled. Dr. Eilers also opined petitioner was permanently and totally disabled. Although Dr. Eilers felt petitioner was possibly able to do sedentary work, at best. Dr. Eilers believed petitioner was functionally totally disabled as petitioner's restrictions would limit her ability to work to maybe one to two hours a day at best, and other days not at all.

Once Dr. DePhillips and Dr. Eilers determined petitioner was medically permanently and totally disabled, the burden shifted to respondent to prove petitioner was employable. The only contrary opinion of Dr. DePhillips and Dr. Eilers, as to petitioner's permanent disability, was that of Dr. Salehi. However, Dr. Salehi offered the same opinion in November, 2014 as to petitioner's disability as he did in July, 2011, that had been rejected by the Commission.

Therefore, the Arbitrator finds petitioner proved she is permanently and totally disabled as of September 22, 2014 at the minimum permanent total disability rate of $461.78 per week.

M. In support of the Arbitrator's decision with regard to penalties and fees, the Arbitrator finds the following:

Respondent stipulated no temporary total disability was due after the date of Dr. Salehi's examination on November 4, 2014. Thus, by respondent's own admission, temporary total disability should have been paid to the date of November 4, 2014. Accordingly, by respondent's own admission, petitioner was due temporary total disability for the period from March 29, 2012

to November 4, 2014, which is 135-6/7 weeks at the TTD rate of $357.37, for a total of $48,586.59. However, respondent paid only $34,494.43.

Furthermore, respondent relied upon the opinion of Dr. Salehi to deny disability benefits after November 4, 2014. However, Dr. Salehi's opinion in November, 2014 was the same opinion from July, 2011, that had been rejected by the Commission. Therefore, respondent's reliance upon Dr. Salehi's opinion to stop payment is without merit and thus unreasonable, unjustified and vexatious.

Although there is a reasonable question as to when petitioner would be determined to be permanently and totally disabled, which would make her eligible for the minimum permanent total disability rate, for purposes of determining penalties, the Arbitrator finds petitioner was entitled, at a minimum, TTD from March 29, 2012 through May 10, 2016, which is 214-6/7 weeks. Thus petitioner should have been paid $76,783.50 (214-6/7 weeks @ $357.37 per week) since the last hearing. Respondent paid only $34,494.43.

Respondent's actions, by failing to pay TTD to which they agreed and reliance upon the opinion of Dr. Salehi that had already been rejected by this Commission, was unreasonable and vexatious. Thus, an award of penalties to petitioner at 50% of $42,289.07 [$76,783.50 TTD owed (from March 29, 2012 to May 10, 2016) less $34,494.43 paid], or $21,144.54 under § 19 k of the Act, is warranted.

Respondent is also responsible to pay 20% of $42,289.07, or $8,457.81 in attorneys' fees under §16 of the Act,

N. In support of the Arbitrator's decision with regard to credit due respondent, the Arbitrator finds the following:

Respondent is entitled to the credit of $34,494.43

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

MARK A. BILECKI,

Petitioner,

vs.

NO: 15 WC 000170

MODERN DROP FORGE,

18IWCC0148

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 and causal connection, medical expenses and temporary total disability benefits, and being advised in 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.

As did the Arbitrator, the Commission finds the opinions of Dr. Chiodo more persuasive than those of Dr. Garapati and accordingly affords greater weight to Dr. Chiodo's opinions. To the extent the Arbitrator dis-counted Dr. Garapati's opinion at the onset given his testimony as to a possibility, the Commission strikes such finding as a misstatement of the law. As the court noted in *Matuszak v. Cerniak*, 346 Ill. App. 3d 766, 772, 805 N.E.2d 681 (2004), "It is permissible for a medical expert to testify concerning his or her opinions in terms of possibilities or probabilities. [citation omitted]. The expert may testify to what might or could have caused an injury despite an objection that the testimony is inconclusive. [citation omitted]. The testimony need not be based on absolute certainty, but only a reasonable degree of medical and scientific certainty. [citation omitted]."

Even weighing Dr. Garapati's opinion accordingly, the Commission affords greater weight to Dr. Chiodo's opinion. As the Arbitrator noted, Dr. Chiodo is a medical doctor board certified in internal medicine with a subspecialty in pulmonary medicine, occupational medicine as well as public health and preventive medicine. Dr. Chiodo is a biomedical engineer, an industrial hygienist

which qualifies and controls air toxins in industrial environments, a toxicologist, epidemiologist, and a biostatistician. Dr. Chiodo testified "In my opinion the cause of his COPD was his long-term cigarette smoking history. There is no causal connection, either by way of causation or aggravation between his work and his COPD." RX7, p. 37. In formulating his opinion, Dr. Chiodo obtained a history of exposure from Petitioner; reviewed Petitioner's medical records including the opinions of Dr. Garapati, Petitioner's treating physician; and reviewed certain reports- material safety data sheets, industrial hygiene exposure study and test America analytical report. Petitioner objected to Dr. Chiodo's reliance on the reports based upon *Ghere v. Industrial Commission*. The Arbitrator overruled the objection, and the Commission concurs based upon Illinois Rules of Evidence, Rule 703 previously adopted by *Wilson v. Clark*, 84 Ill. 2d 186 (1981) (If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence).

In his brief, Petitioner argues Dr. Chiodo's opinions are speculative, but the Commission disagrees. Dr. Chiodo thoroughly explained the basis of his opinions- initially explaining the difference between obstructive lung disease such as COPD which is difficulty getting air out of the lungs versus restrictive lung disease such as sarcoidosis which is difficulty getting air into the lungs. As the Arbitrator found:

> Dr. Chiodo offered an explanation as to why the graphite and/or iron oxide dust particles did not aggravate Petitioner's COPD. Dr. Chiodo testified COPD affects the lower respiratory tract, not the upper airways, and he testified that an irritant has to be either a gas or a very fine dust particle to get down deep into the lungs. Therefore, the physical nature of graphite and/or iron oxide dust prevents it for impacting COPD, according to Dr. Chiodo's explanation of the Material Safety Data Sheets and based upon Petitioner's own testimony that he could see the dust particles in the air, as well as Petitioner's wife's testimony that he would come home from work covered in this type of dust.

The Arbitrator further explained:

> Dr. Chiodo also reviewed an industrial hygiene study and reported low levels of graphite and iron oxide dust in the air of Respondent's plant- far lower that the permissible limit established by OSHA. Additionally, Dr. Chiodo testified to performing a peer review medical literature search that did not support Dr. Garapati's assertion that graphite and/or iron dust aggravated Petitioner's COPD.

To the extent, Dr. Chiodo reviewed the test American analytical report prepared in 2002 which predated Petitioner's employment, the same was not relied upon by the Arbitrator nor the Commission in its decision.

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

IT IS FURTHERED 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 accident 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: MAR 13 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 011718
49

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

BILECKI, MARK A
Employee/Petitioner

Case# 15WC000170

MODERN DROP FORGE
Employer/Respondent

18IWCC0148

On 5/25/2016, 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:

4678 PARENTE & NOREM PC
PARAG P BHOSALE
221 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
MICHAEL P GEARY
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

18IWCC0148

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MARK A. BILECKI
Employee/Petitioner

v.

MODERN DROP FORGE
Employer/Respondent

Case # 15 WC 000170

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **GEORGE ANDROS**, Arbitrator of the Commission, in the city of **CHICAGO, IL**, on **February 18th and March 22nd, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0148

FINDINGS

On the date of accident, 11/21/2014, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $45,760.00; the average weekly wage was $880.00.

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

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

Respondent shall be given a credit of $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

GIVEN THAT THE ARBITRATOR FINDS NO CAUSAL CONNECTION BETWEEN THE ACCIDENT/EXPOSURE AND THE PETITIONER'S PRESENT CONDITION OF ILL BEING, BENEFITS ARE DENIED UNDER THE WORKERS COMPENSATION ACT.

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

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

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

#001 George J. Andros

Signature of Arbitrator

May 23, 2014

Date

ICArbDec19(b)

MAY 25 2016

FINDINGS OF FACT 15 WC 000 170:

Petitioner testified on direct examination that he is a 61-year-old married father of three grown children. After graduating high school in 1972 he worked as a stock boy at Walgreens for two years. He then went to DeVry for two years where he studied electronics technology. He next worked for 28 ½ years at Rockwell International until he was laid off. When working at Rockwell, he worked in a very clean environment. In September of 2004 he was hired by the Respondent as a maintenance electrician. While working for the Respondent he became a member of the Machinists and Aerospace Workers' Union. He was employed by the Respondent continuously from 2004 until 2014, working as an electrician the entire time.

The Respondent is in the business of producing steel forgings for various other companies including Harley Davidson and Mercury Marine. They also produce heavy steel forgings that are used in the oil industry. The Petitioner worked at the hundred-year-old plant located at 13810 S. Western Avenue, in Blue Island, IL. Six out of the ten buildings in the complex were production buildings.

Mark worked 8 hours per day, 5 days per week. His work included electrical work, changing coils for induction furnaces, repairing motors, changing motors, and anything else involving electric work – even changing light bulbs. As part of his job he would have to climb up 20 stairs to get above the induction furnace.

All of the production buildings were indoors, but some of them were very cold in the winter. In some of the buildings the air wasn't that bad because the doors were kept open, but buildings #4 and #5 were sealed so the air quality was terrible. Those two buildings housed three large presses that were lubricated by a mixture of graphite and water. The graphite and water mixture was sprayed onto hot "dies" (molds kept at 300 – 400 degrees to cast liquid steel). When the mixture would hit the dies, the water would evaporate but the graphite would stay in the air. An example of the graphite dust was identified in Petitioner's Exhibit 7. The gray dust on the left side of the photograph is graphite. Mark took this photograph in 2013 because he wanted to show the dust to his doctor. Mark would spend no less than six hours per day, 5 days per week in buildings #4 and #5, breathing this dust the entire time.

In addition to graphite, Mark noticed iron dust in the air. It was visible all over his arms and his clothing, and he would have black streaks of it under his nose at the end of each day. The level of the graphite and iron dust in the air was consistent during the 9 years that he worked for the Respondent. He would often get a sore throat from inhaling the air. He tried wearing a filtration mask, but he also had to wear large safety glasses and they would fog up when he wore the mask, making it impossible to see. The Respondent did not require him to wear a mask.

Prior to his employment with Respondent, Mark had been a smoker. He smoked for about 30 years until 2005 when he was diagnosed with COPD. Despite the COPD, he was able to work for the Respondent continuously from December of 2005 until November of 2014.

On 11/06/14, Mark's wife took him to St. Joseph's Medical Center because he was having upper respiratory problems. The next day he underwent a breathing test, and thereafter was referred to Dr. Amar Garapati. On 11/19/14, Dr. Garapati advised him to stop working in an environment with such poor air quality.

Having received this restriction, on 11/21/14 Mark had a meeting with his supervisor Chuck Warzalek. Warzalek told him that he would have to resign if he wanted access to his 401(k), so that's was Mark did. He had no plans to resign prior to seeing Dr. Garapati, but because he needed the 401(k) money now that he would not have income from work, he had to resign. Dr. Garapati referred Mark for a sleep study on 12/22/14. He had a final appointment with Dr. Garapati on 1/28/15 where they went over the results of the test. Mark wasn't able to go back to Dr. Garapati because Dr. Garapati didn't accept Public Aid as insurance, and Mark had no other means of paying for the visits.

Mark then switched his treatment over to Dr. Sean Forsythe because he did accept Public Aid insurance. His doctors have recommended that he try to lose some weight to alleviate his COPD symptoms. Mark has tried to walk but he can't make it far because he gets winded very easily. He also gets winded when climbing stairs. If he was physically able to continue doing his job, he would never have resigned.

On cross-examination, Mark testified that he smoked for 30 years prior to 2005; not 40 years as the records from Loyola may state. He is the heaviest he has ever been right now at 315 lbs. He has not looked for a new job since resigning. On re-direct, Mark testified that the amount of dust in the air in the years leading up to his resignation was greater than it was when he first started working for the Respondent in 2005. In 2014 the Respondent began moving equipment out of Buildings 4 and 5 to their new plant in Indiana. They removed the normal furnace which required them to keep the roofs closed to combat the cold. This increased the level of particulates floating in the air. This is persuasive to the Arbitrator relative to the difference in exposure in the period in question.

Linda his spouse has been married to Mark for 37 years. She has a medical background and training as a CNA. On 10/29/14, she took him to the hospital because she noticed that he had been coughing and had nasal secretions that were pure black. She also put him on an oximeter that they had at home for her 90-year-old mother. Even though Mark had been diagnosed with COPD prior to 2005, he testified he did not really have any trouble breathing between 2005 and 2014.

While Mark was working for the Respondent, Linda noticed that when he would take a shower after work, there was always black residue on the shower walls and around the tub. She also would have to wash his clothes in a separate load of laundry because the water would turn black and bleed into other clothes.

Dr. Garapati is a fellowship-trained, board-certified pulmonary and critical care physician who has been practicing since 2004. He is the Chairman of Medicine at Silver Cross Hospital's Department of Medicine and the Director of the Intensive Care Unit.

He first saw Mark on 11/19/14. He was referred to him by his primary-care physician for exertional dyspnea, which is shortness of breath. He also had a prior diagnosis for COPD (chronic obstructive pulmonary disease.) After smoking 2 packs per day for 30 years, Mark quit smoking in 2005. He was also exposed to dust at work.

Some of the causes of COPD include an extensive history of smoking, genetics, and environmental exposures. There is no cure, but it can be treated. It can also get worse over time. To treat COPD, Dr. Garapati first suggests that you take the person away from the causative factor – in this case, the dust at work.

Dr. Garapati suggests that his patients avoid any industrial dust if possible because there is potential that it may make COPD symptoms worse. One of his recommendations on 11/19/14 was for Mark to work in a clean environment and avoid the dust. He also suggested that he wear a protective mask if exposure to the dust had to continue. He gave him two medications and advised him to try to lose some weight as well. Last, he wanted a sleep study performed. He issued a note ordering him to "avoid fumes and dust" at work.

He saw him again on 1/28/15. He made the same recommendation to avoid dust at work and to wear protective gear.

His last note was from 3/11/15, and on this date he met with Linda Bilecki. In his notes, Dr. Garapati recorded that Mark's COPD was likely "a result of his extensive history of smoking[,]" but "[h]e does have history of exposure to graphite and iron dust at work which is also a likely contributing factor." (PX.1, p.20-21.) His functional status was fairly limited, and he was unable to work his current job. Dr. Garapati testified that his opinions have not changed from when he dictated that note.

To a reasonable degree of medical certainty, Dr. Garapati believed that Mark's exposure to graphite and iron dust at work was a factor that caused an aggravation of his COPD. (PX.1, p.22.) Ideally Mark should avoid working in an environment where he was not exposed to graphite or iron dust. Having not seen him or his wife since 2015, he had no reason to believe that Mark's condition had improved.

Advocate Medical Group – Occupational Health records (PX.3):

Mark was seen on 5/21/12 (2+ years before this occupational exposure) for a right knee issue. His only medication at the time was methocarbamol, which is for musculoskeletal issues. There is no record of any COPD-related complaints or medications being taken.

He was seen again on 9/07/12 for a return to work evaluation for his knee. There is no mention of any COPD-related issues.

Presence St. Joseph Medical Center records (PX.4):

These records indicate the following:

6/21/02 – an ear problem
1/13/05 – an ear problem
12/08/05 – smoking cessation advised
12/13/05 – chronic bronchitis and COPD diagnosis
5/20/08 – hernia repair
1/27/12 – an upper respiratory infection, bronchitis, and COPD
2/18/13 – a hand laceration
10/29/14 – an acute COPD flare-up
11/07/14 – pneumonia

These records are consistent with the Petitioner's testimony. He did not have a significant episode of COPD aggravation that required him to miss work during the time that he worked for the Respondent (2005 – 2014).

Dr. Sean Forsythe (Loyola) records (PX.5):

On 5/13/15, Dr. Forsythe noted that Mark came to see him because he no longer had private insurance. His note states that his severe COPD was likely the result of the "combination of 120-pack year smoking history and working in a metal forge for 10 years." (PX.5,p.13.)

On 10/28/15, Dr. Forsythe noted that Mark's dyspnea is worse when he tries to walk his dogs or climb one flight of stairs.

C. The occupational disease arose out of and in the course of petitioner's employment

An occupational disease arises out of employment when the disease has its origin or *aggravation* in a risk connected to the employment and must naturally result from that risk. 820 ILCS 310/1(d) (emphasis added).

He never would have been exposed to graphite or iron oxide dust if he did not work for the Respondent. The Petitioner described in detail how the graphite dust would end up in the air of the plants where he performed his work. The graphite-water mixture was sprayed onto the hot dies, which caused the water to vaporize and leave the graphite to form dust. The Petitioner and his wife described how the black dust would end up on his clothing and all over his body. Most importantly, he testified that the dust would form streaks out of his nose. Clearly these particles were going into his lungs.

The Arbitrator also finds it notable that the manufacturer of the graphite lubricant places a warning on its product that a pre-existing pulmonary disorder can be aggravated by prolonged exposure to graphite dust. Based on the Petitioner's testimony, he spent no less than 6 hours a day, 5 days a week in this environment. This would amount to prolonged exposure.

E. Respondent was notified of the occupational disease on the manifestation date

The Occupational Disease Act requires that notice be given "as soon as practicable after the date of the disablement." 820 ILCS 310/6(c).

The Petitioner's unrebutted testimony was that he had a meeting with his supervisor Chuck Warzalek on 11/21/14. At that meeting he informed him that he could no longer continue working for the Respondent per the recommendations from Dr. Garapati. This was the first opportunity he had to report his condition after seeing Dr. Garapati. With no evidence to the contrary, the Arbitrator finds that sufficient notice was provided.

Dr. Garapati testified on direct-examination that he first saw Petitioner on November 19, 2014, who provided a history of COPD and reported smoking 2 packs of cigarettes per day for 30 years until quitting in 2005. Dr. Garapati testified that he tells his patients to avoid any industrial dust, if possible, so he advised Petitioner to work in a clean environment, if possible. He provided a work restriction to avoid fumes and dust.

When asked specifically on direct-examination whether Petitioner's exposure to graphite and iron dust at work aggravated his COPD, Dr. Garapati testified it was possible. Dr. Garapati testified that Petitioner's smoking history was a contributing factor to the flare-up of his COPD in 2014 due to the decline in lung function even after smoking stops, and he further testified that he thinks the exposure to dust and fumes at work also contributed. Dr. Garapati testified that he is not aware of any type of test that is able to determine whether exposure to graphite or iron dust caused the flare-up in Petitioner's COPD. When asked what about graphite and iron dust can trigger COPD symptoms, Dr. Garapati testified that he is unable to answer the question with any specificity. He testified that he was not sure with graphite, and that he tried to look up iron and found studies that show people who are ironworkers have an independent risk factor for developing COPD, depending on the amount of the exposure.

On cross-examination, Dr. Garapati testified that he examined Petitioner on two occasions and diagnosed severe COPD. He testified that the COPD was likely a result of Petitioner's extensive history of smoking, which included 2 packs per day for 32 years, as smoking is the most well-known cause and most significant risk factor for COPD. Dr. Garapati testified that living a sedentary lifestyle and being overweight can negatively impact COPD, and he acknowledged that his records indicate that Petitioner did not regularly exercise and was morbidly obese.

Dr. Garapati testified that he was not aware of any specific materials that Petitioner encountered at work, and that he has never seen any air quality reports for Petitioner's workplace. Dr. Garapati testified that he does not know how long Petitioner was exposed to any specific work materials, which he acknowledged would be important information to know when forming a causation opinion.

Dr. Chiodo testified that Petitioner described his work environment during the Section 12 examination on September 9, 2015, which was consistent with the description Petitioner provided to Dr. Garapati. During his deposition, Dr. Chiodo testified that COPD affects the lower respiratory tract, deep down in the bronchials leading to the alveoli of the lungs in the small airways, not the upper airways. COPD does not affect the upper airways, like the throat, larynx, and trachea, according to Dr. Chiodo's testimony.

Dr. Chiodo reviewed the Material Safety Data Sheets for Lubrodal and testified that inhalation low volatility means it does not readily evaporate so it is not expected to cause respiratory tract irritation during normal conditions of use. Additionally, Dr. Chiodo testified that high levels will cause irritation of the eyes or nose, but not deep down in the lungs.

Dr. Chiodo also reviewed an industrial hygiene study from October 6, 2008, and testified that the results showed that the total level of dust in the air at the Respondent's plant was less than 1/19th of the level that OSHA permits. According to Dr. Chiodo, this represents a very low level of dust, inconsistent with the information provided the Petitioner. In reference to Lubrodal, the graphite product used in the forging process, Dr. Chiodo testified that the permissible exposure limit for graphite dust is 15 milligrams per meter cube. Dr. Chiodo testified that the actual concentration of graphite found in the air on October 6, 2008 was .33 milligrams per meter cube, or 1/45th of the level that OSHA permits.

According to Dr. Chiodo, this represents a very low level of graphite. In reference to iron oxide, Dr. Chiodo testified that the OSHA permissible limit is 10 milligrams per meter cube, while the actual concentration of iron oxide found in the air was .041, or 1/243rd of the permissible amount.

Dr. Chiodo testified that he performed a search of the peer review medical literature, using the database of the National Library of Medicine that is maintained by the U.S. Federal Government, to find support for Dr. Garapati's opinion that exposure to graphite dust or iron oxide dust can cause or aggravate COPD. According to Dr. Chiodo, there is no connection, either by way causation or aggravation, between Petitioner's work and his COPD.

On cross-examination, Dr. Chiodo testified that there is no literature to support the claim that graphite dust exposure can cause or aggravate COPD, which he stated is a strong indication that it is highly improbable that such an exposure can cause or aggravate COPD. Dr. Chiodo testified in more detail about the upper and lower airway on cross-examination, noting that an irritant has to be either a gas or a very fine dust particle to get down deep into the lungs. Dr. Chiodo testified that Material Safety Data Sheets have an incentive to over-warn of the potential risk when handling the material in question due to liability concerns. Dr. Chiodo testified that just because Dr. Garapati is making an assertion that is not supported by the literature does not mean that Dr. Garapati is not a good pulmonologist. In fact, Dr. Chiodo testified that Dr. Garapati's assertion may seem logically intuitive, but it is just not supported on an epidemiologic basis.

ADDITIONAL CONCLUSION OF LAW 15 WC 000170

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

Based upon the totality of the evidence, the Arbitrator finds by a preponderance of the evidence that Petitioner failed to establish he sustained an accidental exposure arising out of and in the course of his employment by the Respondent that is causally related to his current condition of ill-being.

In support of this conclusion, the Arbitrator finds Dr. Chiodo more persuasive than Dr. Garapati. Therefore, he places greater weight on Dr. Chiodo's causal connection opinion that Petitioner's work environment did not cause or aggravate his underlying COPD condition.

The Arbitrator finds Dr. Chiodo's opinion more persuasive than Dr. Garapati's opinion for a multitude of reasons.

Dr. Chiodo offered an explanation as to why the graphite and/or iron oxide dust particles did not aggravate Petitioner's COPD. Dr. Chiodo testified COPD affects the lower respiratory tract, not the upper airways, and he testified that an irritant has to be either a gas or a very fine dust particle to get down deep into the lungs. Therefore, the physical nature of the graphite and/or iron oxide dust prevents it from impacting COPD, according to Dr. Chiodo's explanation of the Material Safety Data Sheets and based upon Petitioner's own testimony that he could see the dust particles in the air, as well as Petitioner's wife's testimony that he would come home from work covered in this type of dust.

Dr. Chiodo also reviewed an industrial hygiene study and reported low levels of graphite and iron oxide dust in the air of the Respondent's plant – far lower than the permissible limit established by OSHA. Additionally, Dr. Chiodo testified to performing a peer review medical literature search that did not support Dr. Garapati's assertion that graphite and/or iron dust aggravated Petitioner's COPD.

On the other hand, as an initial matter the Arbitrator finds that Dr. Garapati's testimony is insufficient for Petitioner to establish his threshold burden of proof. Specifically, when asked on direct-examination whether his causation opinion was based on a reasonable degree of medical certainty, Dr. Garapati testified that it was "possible" that the dust at the Respondent's plant aggravated Petitioner's COPD. The Arbitrator notes that "possible" is not a recognized standard. Additionally, Dr. Garapati was asked on direct-examination what about graphite and iron dust can trigger COPD symptoms; in response, he admitted that he was unable to answer the question with any specificity. When Dr. Garapati tried to answer the question in general terms, he admitted that he really was not sure about graphite, and he stated that he was able to find studies that show ironworkers have an independent risk factor for developing COPD. Based on this testimony, the Arbitrator finds that Petitioner cannot meet his threshold burden of proof.

Even if the Arbitrator found Dr. Garapati's opinion sufficient to establish causal connection, the Arbitrator is still persuaded by Dr. Chiodo. Dr. Garapati admitted that he had no knowledge of Petitioner's work environment, the materials Petitioner worked with at the Respondent's plant, or the amount of exposure at issue in this claim; however, Dr. Garapati conceded that this information would be important when analyzing causation. Dr. Garapati's opinion is based solely upon Petitioner's verbal job description.

Petitioner admitted that he told both Dr. Garapati and Dr. Forsythe at his first office visit with each physician that his COPD was aggravated by his work environment. Dr. Garapati testified that smoking is the most significant risk factor for COPD and that being overweight and having a sedentary lifestyle can negatively impact COPD, and then Dr. Garapati acknowledged that Petitioner had smoked 2 packs per day for 32 years, does not regularly exercise, and is morbidly obese. In fact, Petitioner testified that his doctor told him that he had to lose weight or the increased COPD symptoms could kill him.

Dr. Chiodo is board-certified in internal medicine, occupational medicine, and public health & general preventative medicine, and he is a certified industrial hygienist. Dr. Chiodo has a Master of Science in Occupational & Environmental Health Sciences with a specialization in Industrial Toxicology, which he testified focuses on what type of exposures people would suffer in various work environments, and whether those exposures can cause disease.

In view of the Arbitrator's findings in reference to causal connection, the Arbitrator finds the remaining issues 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

Miguel Angel Depaz Barcenas,
Petitioner,

vs. NO: 10 WC 43615

18IWCC0149

Carniceria Del Rio; Jaime Salas, individually and d/b/a Carniceria Del Rio; Ill. State Treasurer as ex-officio Custodian, Injured Workers Benefit Fund,
Respondent.

DECISION AND OPINION ON REVIEW

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

In further support of the Arbitrator's conclusions, the Commission notes the longstanding principle that "[t]he mere existence of testimony by an interested party does not require its acceptance." *United States Steel Corp. v. Industrial Commission*, 8 Ill.2d 407, 413 (1956). Even unrebutted testimony need not be accepted, so long as there exists a sound reason for doing so. *Sorenson v. Industrial Comm'n*, 281 Ill. App. 3d 373, 384 (1996); *Fickas v. Industrial Comm'n*, 308 Ill.App.3d 1037, 1041-42 (1999) (stating that the Commission is not required to accept unrebutted testimony). Moreover, the Appellate Court has noted that "...the sole medical opinion may not be arbitrarily rejected. However, 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 (2nd Dist. 1997), and see *Sorenson v. Industrial Commission*, supra.

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The Arbitrator reasoned that the initial medical treatment at St. Anthony's for a mild wrist sprain was related to the injury. However, extended chiropractic treatment beginning more than a month after the injury for what the claimant asserted was a paralytic hand was not reasonable or based on credible evidence. This reasoning, and the resulting award, were well supported by the totality of the adduced evidence, including the ER diagnosis of only a mild sprain with normal range of motion on physical examination at the time.

In so affirming the Arbitrator's Decision, the Commission corrects one error; in the Order section of the Decision, the Arbitrator awarded $1,100.00 in medical expenses from St. Anthony Hospital. However, the rider of the decision notes the medical bill as $1,114.00, and the medical bill exhibit confirms the amount of the bill was $1,114.00. The Order is therefore corrected to read $1,114.00, subject to Sections 8(a) and 8.2 of the Act.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as noted above, the Decision of the Arbitrator filed June 29, 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: MAR 14 2018

Joshua D. Luskin

o-01/17/18
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Charles J. DeVriendt

18IWCC0149

SPECIAL CONCURRING OPINION

Petitioner argues the Commission is bound as a matter of law by Petitioner's seemingly uncontradicted testimony relying on *People ex rel. Brown v. Baker*, 88 Ill. 2d 81, 85, 430 N.E.2d 1126 (1981) ("Where the testimony of a witness is neither contradicted, either by positive testimony or by circumstances, nor inherently improbable, and the witness has not been impeached, that testimony cannot be disregarded even by a jury. [citation omitted].") The Commission notes Petitioner's attorney advanced the same argument in *Hosteny v. Illinois Workers' Compensation Commission*, 397 Ill. App. 3d 665, 928 N.E.2d 474 (2009). In rejecting the argument, the Court noted "[a]lthough an employee's testimony about an alleged accident might be sufficient, standing alone, to justify an award of benefits under the Act, it is not enough where consideration of *all* facts and circumstances demonstrate the manifest weight of the evidence is against it. [citation omitted] (emphasis in the original)." *Id.* at 677.

Petitioner testified after falling onto his hand on August 26, 2010, he presented to St. Anthony Hospital emergency room on August 28, 2010, two days later. The medical records from this visit indicate a consistent history of injury. Of note, Petitioner advised when the accident initially occurred on August 26, 2010, his symptoms were severe, but by the time of the visit, Petitioner advised his symptoms were mild. The physical examination findings indicate "No cyanosis, clubbing, edema. Normal range of motion, swelling at dorsum of hand. Mild ecchymosis at the mid mcp area at base of 3rd and 4th digits." PX8. The radiology interpretation notes "X-ray of the left hand shows, hand negative, no fractures, no dislocation, no foreign body, no bony lesions, no degenerative joint disease, no soft tissue swelling." PX8. Given such it is unclear if swelling was even present as of August 28, 2010.

Petitioner was diagnosed with a wrist sprain and provided a splint. Upon discharge, Petitioner's pain was noted to be a 2. Petitioner was advised to follow-up with his primary care physician, Dr. Mitchell Goldflies and to return to the emergency room if his condition worsened. PX8. Petitioner failed to do either. Instead Petitioner waited six weeks and sought treatment from a chiropractor allegedly due to his hand becoming "paralyzed." The Commission finds it difficult to believe if Petitioner's symptoms were increasing so drastically, why he would not consult with his primary care physician or at a minimum return to the emergency room as previously instructed.

In any event, Petitioner's testimony that his hand was paralyzed is contradicted by the medical evidence as is his testimony that he no longer has movement in two of his fingers. Petitioner presented to Affiliated Chicago Physicians on October 15, 2010 with complaints in his left hand of pain which was dull/achy as well as sharp as well as radiating along with numbness. No objective testing is documented as to Petitioner's range of motion, strength or sensation but merely his subjective complaints. It is unclear from the records whether Petitioner was even evaluated by Dr. Magnan as he failed to sign the record. PX9.

Petitioner continues to receive chiropractic care for months without any documented objective findings. The notes do indicate exercises for range of motion, joint mobilization and stretching which certainly indicates Petitioner is able to move his hand despite his testimony to the contrary. Petitioner argues the word "paralyzed" is, in effect, taken out of context. Such argument is not well-founded. A translator was present which allowed Petitioner to testify in his native language. Petitioner utilized the word "paralyzed" and further testified "these two fingers, here, I no longer have movement." T. 32. Petitioner attempts to reconcile the clear contradiction between Petitioner's testimony and the medical evidence by redefining the meaning of paralyzed. Paralyzed is defined as "to cause paralysis in." Paralysis is defined as "partial or complete loss, or temporary interruption of a function esp. of voluntary motion or sensation in some part or all of the body." *Webster's New World Dictionary, Second College Edition.* Petitioner's testimony that his hand was paralyzed, and he lost all movement in two of his fingers is simply not credible. Moreover, the scant records from Affiliated Chicago Physicians which do not document any objective physical findings are almost indecipherable but belie Petitioner's argument as they document normal range of motion and sensation.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DEPAZ BARCENAS, MIGUEL ANGEL
Employee/Petitioner

Case# **10WC043615**

18IWCC0149

DEL RIO, CARNICERIA; SALAS, JAIME INDV & D/B/A DEL RIO, CARNICERIA; ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 6/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

0147 CULLEN HASKINS NICHOLSON ET AL
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KELLY KAMSTRA
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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

18IWCC0149

Miguel Angel Depaz Barcenas
Employee/Petitioner

Case # 10WC043615

v.

Consolidated cases: ____

Carniceria Del Rio; Jaime Salas individually & d/b/a Carniceria Del Rio; Illinois State Treasurer as ex-officio Custodian, Injured Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **January 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 **Were Respondents insured; Were Respondents provided notice?**

FINDINGS

On **08/26/2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**13,300.00**; the average weekly wage was $**266.00**.

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

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

Respondent ***has 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

Respondents, Carniceria Del Rio and Jaime Salas, individually and doing business as Carniceria Del Rio shall pay the Petitioner a total of $1,100.00 for reasonable and necessary medical services pursuant to section 8(a), section 8.2, the medical fee schedule and the holding in Springfield Urban League v. Ill. Workers' Comp. Comm'n, 2013 Il App (4th) 120219WC

Respondents, Carniceria Del Rio and Jaime Salas, individually and doing business as Carniceria Del Rio shall pay Petitioner no temporary and total disability benefits.

Respondents, Carniceria Del Rio and Jaime Salas, individually and doing business as Carniceria Del Rio shall pay Petitioner permanent partial disability benefits at the minimum rate of $220.00/week for a total of 0 weeks, because the injuries sustained caused permanent injury.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Signature of Arbitrator

06-28-16
Date

JUN 29 2016

Attachment to Petitioner's Proposed Arbitration Decision
Miguel Angel De Paz Barcenas v.
Carniceria Del Rio; Jaime Salas, individually and d/b/a Carniceria Del Rio; Illinois State Treasurer as ex-officio Custodian, Injured Workers' Benefit Fund
10WC043615

FINDINGS OF FACT

This matter was heard on January 15, 2016 in Chicago, Illinois. The Petitioner was present and represented by counsel. The Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as ex-officio custodian of the Injured Workers' Benefit Fund. Respondent, Jaime Salas, was present and was not represented by counsel at trial.

Respondent testified that he was the owner of Carniceria Del Rio from 2007 until it closed in approximately October 2010. Respondent testified that his business was located at 2714 W. Cermak Rd., Chicago, IL. Mr. Salas testified that his place of business was a grocery store that sold fresh meat and had a butcher department. Respondent stated that he was the only butcher at the grocery store and that he did not have any employees. Respondent also testified that on August 26, 2010 he had a business license from the City of Chicago to operate Carniceria Del Rio and that he was the sole proprietor of the business. Additionally, Mr. Salas stated that he and his mother, Maria Salas were the only ones who operated and ran the business and never had any employees.

Petitioner, Miguel Angel De Paz Barcenas, testified that he was hired by Maria Salas in approximately February 2010 to work as a butcher for Respondent. Petitioner stated he learned the Respondent was seeking to hire a butcher when he read a job posting placed on the door at Respondent's place of business. Petitioner testified that he went inside the store to inquire about the position and spoke with Maria Salas. He stated Maria Salas tested his butcher skills and hired him.

Petitioner's supervisor at work was Maria Salas. Maria Salas controlled Petitioner's work schedule. Petitioner testified that Monday through Friday he worked approximately 6 hours per day and that on Saturdays and Sundays he worked approximately 8 to 10 hours per day. Petitioner testified that he was not allowed to create his own work schedule. Petitioner indicated he earned an hourly wage of $6.00 per hour. Petitioner also testified that he was paid in cash by Maria Salas on Sundays and that during the time he worked for Respondent he did not have a bank account.

Petitioner indicated that as a butcher he was required to cut and prepare raw meat in the butcher department as well as sweep and mop the butcher's area. During the course of his employment, Petitioner used sharp edged tools such as knifes and handled machines with sharp edges such as the meat grinder and meat slicer. Respondent provided all the tools used by Petitioner during his course of employment. Petitioner did not provide any of his own tool while working with the Respondent. Petitioner testified that in his occupation he wore an apron provided by the Respondent. Respondent controlled Petitioner's job responsibilities. Petitioner testified that he had approximately 3 co-workers aside from his supervisor, Maria Salas, and the owner of the grocery store, Jaime Salas.

Petitioner stated that as an employee he had access to parts of the store not available to customers. Petitioner described those parts of the store. He stated that in the butcher department there where two floor mats located between the fresh meat display and the back wall. He described these mats as each being 6 feet long and approximately 1 inch thick, they were black and perforated. Petitioner testified that the butcher area was towards the back of the store. Additionally, he indicated there was a wall dividing the butcher area and a back room, which was used as a kitchen. Petitioner testified that in the back room there was a stove, cooler and table that he used to prepare food sold by the business, as well as a bathroom. Additionally, he described a doorway leading to the alley and garage located at the back of the store off of the kitchen area.

Respondent testified that he would pay Petitioner in cash for services and jobs done at Carniceria Del Rio such as bagging groceries and washing windows, however denied that Petitioner was an employee. Jaime Salas admitted that he intentionally did not purchase workers' compensation insurance for his business, Carniceria Del Rio. Mr. Salas testified that in addition to owning and operating Carniceria Del Rio, he also worked at Rush University Medical Center and was a student in August 2010.

On Thursday, August 26, 2010 Petitioner remained employed by Respondent as a butcher. Petitioner also testified that on August 26, 2010 he was approximately 47 years old, was not married and did not have any minor children.

During the course of working as a butcher for the Respondent on Thursday, August 26, 2010, Petitioner injured his left fourth and fifth digits on his left hand while placing a floor matt down after mopping and cleaning the butcher area. Petitioner testified that his fourth and fifth fingers on his left hand were caught and overextended in the honeycomb style matt as he was placing it down and he fell and landed on his left hand. Petitioner testified that he felt immediate pain in his left hand. Mopping and cleaning the butcher area was part of Petitioner's job responsibilities. Petitioner stated that his injury occurred at approximately 7:30 in the evening and that the store closed at 8:00 p.m. He indicated that he informed the cashier of his injury before leaving work that night. Petitioner testified that his supervisor, Maria Salas, was not at work at the time of his injury.

Petitioner returned to work the following day, however experienced pain in his left hand had difficulty completing his tasks. Petitioner testified that on that day, Friday, August 27, 2010 he notified his supervisor, Maria Salas, that he had injured himself at work while performing his work duties the previous night.

Petitioner first sought medical attention on August 28, 2010 at St. Anthony Hospital. The medical records from St. Anthony Hospital indicate a history that the patient fell at work after tripping on the carpet Thursday. (PX, pg. 11). Additionally those medical records indicate that Petitioner was experiencing swelling and 2/10 pain after falling down and hyperextending his left hand. (PX7, pg. 11). A physical exam indicated that Petitioner had swelling at the dorsum hand and mild ecchymosis at the metacarpal at the base of the third and fourth digits. (PX7, pg. 12). A cock up wrist splint was applied. (PX7, pg. 12). The diagnosis was a left hand sprain. X-rays were negative. (PX7, pg. 13). Petitioner was prescribed Motrin and Tylenol caplets extra strength at that time as well. (PX, pg. 13).

Petitioner testified that he returned to work on Sunday, August 29, 2010 and informed Maria Salas and Jaime Salas that he had sought medical attention for his work related injury. Petitioner testified that he presented documentation from St. Anthony Hospital to Maria and Jaime Salas. Petitioner also testified that he was fired by Maria Salas and Jaime Salas at that meeting. Mr. Salas testified that in approximately August of 2010 he observed Petitioner at Carniceria Del Rio wearing a wrist brace on the left hand. Mr. Salas stated that he offered to take Petitioner to the hospital during the store's business hours. Mr. Salas also testified that Petitioner told him that the Petitioner injured himself at home. Petitioner testified that the Respondent did not provide him with information about workers' compensation insurance.

Six weeks elapsed. Petitioner next sought medical treatment from David Magnan (DCM) at Affiliated Chicago Physicians on October 15, 2010 upon the advice of his attorneys and because his hand "was paralyzed." (PX8, pg. 8). Petitioner testified that from the time he was fired through October 15, 2010 he was not able to work due to pain in his left hand and fourth and fifth ringers. He also testified that he wore the hand brace given to him at St. Anthony Hospital from August 28, 2010 through October 15, 2010. At his initial evaluation with Dr. Magnan, Petitioner complained of sharp pain at the fourth and fifth digits of the left hand. (PX8, pg. 8). At that time, Petitioner rated his pain as being 7 out of 10. (PX8, pg. 8). It was also noted that Petitioner experienced muscle spasms at the biceps and forearm of the left upper extremity as well as tenderness at the left wrist and hand region. (PX 8, pg. 8). Petitioner followed-up with Dr. David Magnan on October 19, 2010 (PX 8, pg. 9). At that time it was noted that Petitioner experienced cramps and numbness which radiated into the forearm on his left upper extremity. (PX 8, pg. 9). On October 21, 2010 Dr. Magnan noted that pain in Petitioner's left forearm wrist and hand was aggravated by grasping objects. (PX 8, pg. 10).

Petitioner continued with a course of chiropractic treatment by Dr. David Magnan at that time. (PX 8). On November 15, 2010, Dr. Magnan noted the presence of limited range of motion of Petitioner's left hand. (PX 8, pg. 17). On December 6, 2010 it was noted that Petitioner lost strength of his left upper extremity. (PX 8, pg. 23). On December 14, 2010 Dr. Magnan noted that Petitioner demonstrated improvements with left wrist strength, but that there was still limited range of motion. (PX 8, pg. 26). On January 18, 2011 Dr. Magnan released Petitioner to return to work with 50 pound lifting restrictions and limited his work day to 8 hours per day. (PX 8, pg. 52). Petitioner testified that the Respondent did not offer to accommodate his work restrictions at any point during the course of his treatment.

Petitioner continued with the course of physical therapy approximately 3 times a week until April 8, 2011. (PX 8). On March 25, 2011 Dr. Magnan noted that Petitioner felt constant cramps in the left forearm. (PX 8, pg. 46). Dr. Magnan released Petitioner to return to work without restrictions on April 8, 2011. (PX8, pg. 51). Petitioner testified that the therapy treatment he received from Dr. David Magnan at Affiliated Chicago Physicians helped alleviate his pain and range of motion issues. Petitioner testified that he received bills from St. Anthony Hospital and Dr. Magnan for the medical treatment he received.

Petitioner stated that prior to August 26, 2010 he had not had an injury to his left hand and left fourth and fifth fingers. Petitioner also testified that prior to August 26, 2010 he did not receive medical treatment to his left hand or left fourth and fifth fingers. Additionally Petitioner indicated

that subsequent to August 26, 2010 he has not suffered an injury to the left hand or fourth and fifth digits of the left hand. At the time of Arbitration Petitioner testified that he still experiences numbness to the left hand and fingers and that he cannot rest his body weight on his left hand. He also testified that he can't grip objects like he did prior to the injury. Petitioner testified that after being discharged by Dr. Magnan he worked for a landscaping company. He claimed to be no longer able to work as a butcher. He still claimed numbness at the top of his forearm and stated that he cannot move two of his fingers. He also testified that the only machine he operated at that time was a leaf blower, which he used his right hand to operate. Later, on cross exam, the Petitioenr stated he no longer has pain.

Jaime Salas testified that he received medical bills from Affiliated Chicago Physicians for medical treatment rendered to Petitioner. Respondent testified that he did not make payments on any of those bills. Additionally Respondent testified that he did not provide workers' compensation insurance information to Petitioner.

CONCLUSIONS OF LAW

With respect to issue A, was the Respondent operating under and subject to the Illinois Workers' Compensation Act or Occupational Disease Act, the Arbitrator finds as follows:

The Arbitrator concludes that the provisions of the Act apply automatically to the employment because the Respondents were engaged in the business that regularly involves the use of sharp edged cutting tools under section 3(8) of the Act. 820 ILCS 305/3.

With respect to issue B, was there an employer/employee relationship, the Arbitrator finds as follows:

The Arbitrator concludes that on August 26, 2010 an employer/employee relationship existed between the Petitioner and the Respondents, Carniceria Del Rio and Jaime Salas individually and doing business as Carniceria Del Rio, because the Respondents exercised the right to control the Petitioner and because the Petitioner was hired by the Respondents during the relevant period of time and the Respondents provided all tools to the Petitioner to accomplish the work. Respondents directed and controlled Petitioner's work activity and Respondents had the right to direct and control Petitioner's work activities. Respondents paid the Petitioner an hourly wage. Respondent's testimony that he and his mom ran the grocery store and never had any employees, including Petitioner is simply not credible.

With respect to issues C & D, did an accident occur and arise out of and in the course of Petitioners employment by Respondent, what was the date of accident, the Arbitrator finds as follows:

The Arbitrator concludes that the Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on Thursday, August 26, 2010. The Arbitrator finds Petitioner's description of the injury to be credible. The histories in the initial and contemporaneous medical records are consistent with the Petitioner's account of the accident, which involve over-extending the fingers on his left hand and landing on this left hand while placing down a floor matt

after cleaning the butcher area. Petitioner provided specific details as to the mechanism of his injury, the layout of his work area and described areas of the grocery store not accessible to nonemployees. Respondent's testimony that Petitioner told him that the Petitioner injured himself at home is simply not credible.

With respect to issue E, was timely notice of the accident given to the Respondent, the Arbitrator finds as follows:

The Arbitrator concludes that Petitioner gave adequate notice of his accidental injury to Respondents within the time limits stated in the Act. Petitioner advised Maria Salas, his supervisor, on Friday, August 27, 2010 of his work injury. Additionally he discussed the medical treatment related to his work injury with Maria Salas and Jaime Salas on Sunday, August 29, 2010. Additionally Petitioner provided them with documentation from St. Anthony Hospital.

With respect to issue F, is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accidental injuries sustained on August 26, 2010. The Arbitrator bases this conclusion in part on the findings related to accidental injuries above. In addition, Petitioner was diagnosed with a left hand sprain on August 28, 2010 at St. Anthony Hospital. The medical records from St. Anthony Hospital indicate a history of a work related injury while working for the Respondent. At the time of the accidental injury, the Petitioner was working full duty performing various butcher and cleaning tasks and was not receiving medical treatment for his left hand or fourth and fifth digits on his left hand or feeling anything unusual about those parts of this body. Given the chain of events as described by Petitioner and the medical records the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury.

With respect to issue G, what where Petitioner's earnings, the Arbitrator finds as follows:

Petitioner stipulated to an average weekly wage of $266.00.

With respect to issue H, what was the Petitioner's age at the time of the accident, and issue I, what was the Petitioner's marital status at the time of the accident, the Arbitrator finds as follows:

Petitioner testified at the time of accident August 26, 2010 he was 47 years old, single with no minor children.

With respect to issue J, were the medical services that where provided to Petitioner reasonable and necessary, has the Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator concludes that the medical services provided to Petitioner at St. Anthony Hospital were reasonable and necessary. The Arbitrator bases his conclusion on the medical records. No other medical treatment and bill are reasonable or necessary. There is a 6 week treatment gap

between the time Petitioner was seen in the ER for a mild sprain and then later with David Magnan (DCM). The Petitioner testified that the sought treatment with the chiropractor upon advice of his attorneys. Further, his testimony that he sought additional treatment because his hand "became paralyzed" not credible.

Respondents did not pay any appropriate charges for any reasonable and necessary medical treatment and the Arbitrator awards the following medical bills to the Petitioner: Respondents shall pay the Petitioner reasonable and necessary medical services pursuant to section 8a, section 8.2, the medical fee schedule and the holding in Springfield Urban League v. Ill. Workers' Comp. Comm'n, 2013 Il App (4th) 120219WC: St. Anthony Hospital, $1,114.00.

With respect to issue K, what temporary benefits are in dispute, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner was not temporary totally disabled from August 28, 2010 through April 8, 2011, as the care and treatment provided by David Magnan (DCM) was neither reasonable nor necessary. That Petitioner was placed on light duty for a mild sprain for 31 & 6/7 weeks is ludicrous.

With respect to issue L, what is the nature and extent of the injury, the Arbitrator finds as follows:

The Arbitrator concludes that the accidental injury sustained by Petitioner caused no permanent injury. The Arbitrator bases this conclusion on the medical records from St. Anthony Hospital that Petitioner suffered a mild sprain of his left wrist. The Arbitrator gives no weight the medical records of David Magnan at Affiliated Chicago Physicians. Petitioner stated on cross-exam that he currently feels no pain.

With respect to issue N, is the Respondent due any credit, the Arbitrator finds as follows:

The Respondent testified that he provided no payment of benefits to the Petitioner since the date of accident of August 26, 2010.

With respect to issue O, were Respondents insured; were Respondents provided notice, the Arbitrator finds as follows:

The Petitioner submitted into evidence Petitioner's exhibit PX 1, a certification of no insurance coverage from the National Council on Compensation Insurance indicating Respondents were not insured during the relevant period (PX1). Jaime Salas testified that he intentionally did not ever purchase workers' compensation insurance while his business was in operation.

Petitioner submitted into evidence Petitioner's exhibit PX 2, letters sent to Respondents informing them of the January 6, 2016 status call and Petitioner's exhibit PX 3, letters sent to Respondents providing them notice of the January 15, 2016 trial 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)
Petition to Reinstate	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NURUDEEN OREAGBA,

Petitioner,

vs. NO: 12 WC 30854

YELLOW CAB COMPANY,

18IWCC0150

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of reinstatement and being advised of the facts and applicable law, reverses the Decision of the Arbitrator, and reinstates and remands this matter back to the Arbitrator for further proceedings.

Procedurally, this matter was before Arbitrator Kurt Carlson on November 16, 2016 at which time the matter was dismissed. Petitioner's counsel filed her Notice of Motion and Order on December 29, 2016 indicating that her Motion for Reinstatement would be presented on January 5, 2017. Subsequently, the motion was set for hearing on January 12, 2017.

During the January 12, 2017 hearing, Petitioner's counsel stated that this matter was up before Arbitrator Carlson on November 16, 2016. She also had a case up at the Daley Center at 9:00 a.m. that was going to go to trial. T.6. Counsel arrived at the Commission with her client at 8:30 a.m. and was the first in the Arbitrator's line at 8:40 a.m. T.7. Petitioner's counsel stated that when she got in line, the Arbitrator's door was closed and no one was inside. *Id.* She stayed in line for 20 minutes and then left for the Daley Center around 9:00 a.m. so she could check-in and then return to the Commission. She stated that as she was getting in the elevator around 9:00 a.m., the Arbitrator was coming off the elevator. T.8. She went to the Daley Center and returned to the

18IWCC0150

Commission at 9:25 a.m. She noted that there was a line in front of her and 4 to 5 people behind her. T.8. When she appeared before Arbitrator Carlson, she was informed that the case had been dismissed.

Petitioner's counsel located the attorney from the Attorney General's office, but could not locate the attorney from Knell & O'Connor's office. She again appeared before Arbitrator Carlson with the Assistant Attorney General, but the Arbitrator refused to reinstate the case. T.9.

During the January 12, 2017 hearing, Petitioner's counsel stated that she has diligently pursued this matter. Petitioner's counsel submitted a settlement demand to Respondent's counsel on November 9, 2015 and April 4, 2016 demanding $17,267.60 to resolve the matter. PX.1. She also sent Respondent's counsel all the information they had requested. T.10.

The Arbitrator denied Petitioner's Petition to Reinstate stating that Petitioner failed to properly appear before the Arbitrator on November 16, 2016 as required by the Rules. The Arbitrator stated that Petitioner's counsel demonstrated an "obvious unawareness of the procedural rules necessary to effectively prosecute a claim before the Commission." Petitioner failed to serve a copy of the Motion for Reinstatement on the parties as required under Section 7020.70. She filed said motion on December 29, 2016 for a status call on January 5, 2017. The Rule requires service 15 days prior. She also did not sign and submit the appropriate case management form before leaving the Commission on November 16, 2016. The Arbitrator noted that Rule 7030.20(d) requires that the party must appear before the Arbitrator between 8:45 a.m. and 9:15 a.m. Further, Petitioner was woefully lacking in due diligence to bring this case to resolution. Therefore, her Motion to Reinstate was denied.

The Decision of the Arbitrator to Dismiss this claim for want of prosecution was incorrect as it was premised upon a misapprehension of the Commission's then existing Rules. The Arbitrator applied former Rule 7030.20 (d), indicating that since the Petitioner's attorney did not return and appear before him prior to 9:15 a.m. on the morning of November 16, 2016, the claim was dismissed. However, Rule 7030.20(d) was amended and the amendment went into effect on November 9, 2016. Rule 9030.20(d) now requires that the party's attorney of record must appear before the Arbitrator between 8:45 a.m. and 9:30 a.m.

The facts establish that Petitioner's counsel was present and in line for trial by 8:45 a.m. She waited in line until 9:00 a.m. As the Arbitrator was still not present, she left and went to the Daley center to check in. Petitioner's attorney returned to the Commission and was back in line by 9:25 a.m. The Arbitrator's Decision to dismiss this matter was in error as Petitioner's counsel was compliant with Rule 9030.20(d).

The parties have alleged that Petitioner failed to give proper notice relative to the Petition to Reinstate the claim. Though Petitioner's notice may have been deficient, all parties were present and represented by their respective counsel. For this reason, the Commission cannot perceive any

prejudice suffered by the parties Respondent. This defective notice did not divest the Commission of jurisdiction to hear the Petition to Reinstate.

Equally, the tardiness of Petitioner in filing the transcript of proceeding likewise did not prevent the Commission from hearing the matter. The Commission retained jurisdiction for two reasons. Firstly, Section 19(b) of the Act affords the Commission the capacity to allow the Petitioner 30 days additional time to file the record of proceedings below. We so grant the Petitioner leave to file the record, *sua sponte*. Secondly, the Commission reinstates this claim since the action of the Arbitrator was contrary to the then Rule and the Commission never lost jurisdiction to hear this matter.

Finally, the Commission takes note of the objections lodged by the Respondent. The Commission overrules said objections as the parties were present at each hearing and had ample notice to prepare for any and all proceedings.

IT IS THEREFORE ORDERED BY THE COMMISSION, that the Decision of the Arbitrator filed February 2, 2017, is hereby reversed and reinstated for the reasons stated above, and the matter is remanded to the Arbitrator for hearing.

DATED: MAR 15 2018

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
d: 2-20-18
052

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 "Jesse" Morales,
Petitioner,

vs. NO: 08 WC 38358

City of Chicago,
Respondent.

18IWCC0151

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability and 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.

In further support of the Arbitrator's conclusions, the Commission notes substantial evidence of the claimant having exaggerated his symptoms and preventing medical providers from accurately assessing his condition is apparent from the medical records and the testimony elicited at the hearing. It is worth noting the longstanding principle that "[t]he mere existence of testimony by an interested party does not require its acceptance." *United States Steel Corp. v. Industrial Commission*, 8 Ill.2d 407, 413 (1956). Moreover, the Commission observes that while Dr. Goldberg did place medical restrictions on the claimant, those restrictions were based on highly unreliable statements by the claimant and a desire to be an advocate for his patient. The Appellate Court has repeatedly noted "…the sole medical opinion may not be arbitrarily rejected. However, 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 (2nd Dist. 1997), and see *Sorenson v. Industrial Commission*, 281 Ill.App.3d 373 (1996). The Arbitrator's conclusion that Dr. Goldberg's restrictions were unreliable, and therefore invalid, was well supported by the other evidence, including the claimant's having failed 13 out of 14 validity tests on the work conditioning evaluation (see PX10) and repeated allusions to malingering and poor effort being thoroughly documented in the physical therapy records.

18IWCC0151

The Arbitrator concluded that the claimant's testimony was exaggerated and lacking in credibility. The Arbitrator determined that the claimant was at MMI in 2009 and not entitled to TTD thereafter, and further that the claimant was not entitled to a wage differential or "loss of trade" award. These conclusions and determinations were all well supported by the facts adduced and controlling law. The Arbitrator's decision is therefore affirmed in its entirety.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 29, 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: MAR 15 2018

Joshua D. Luskin

o-01/17/18
jdl/ac
68

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORALES, JESSE
Employee/Petitioner

Case# **08WC038358**

CITY OF CHICAGO
Employer/Respondent

On 6/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1747 SEIDMAN MARGULIS & FAIRMAN
STEVEN J SEIDMAN
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
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

Jesus Morales
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **08** WC **38358**

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 **Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **10-05-15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **08-22-08**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**45,955.52**; the average weekly wage was $**883.76**.

On the date of accident, Petitioner was **36** 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 for all TTD, maintenance, or partial disability benefits paid after May 18, 2009.

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

ORDER

No temporary total disability, maintenance, or temporary partial disability benefits are awarded after May 18, 2009. As a result, Respondent is entitled to a credit for any of these benefits paid after this date.

Respondent shall pay Petitioner permanent partial disability benefits of $ 530.26 per week for 75 weeks, because the injuries sustained cause 15% loss of the person as a whole, as provided in Section 8(d)(2) of the Act.

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

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

Signature of Arbitrator

06-22-16
Date

JUN 29 2016

STATEMENT OF FACTS

Mr. Jesus Morales, the 46 year-old petitioner, testified that he has worked for the City of Chicago, Respondent, for 16 years. Petitioner testified that throughout the 16 years he has worked in various capacities. He testified that he started working in the parking enforcement division as a parking meter mechanic. He testified that his duties as a parking meter mechanic were to enforce the parking laws.

Petitioner testified that on August 22, 2008, while working as a parking meter mechanic he was involved in an automobile injury. He testified that while he was on the way to repair a parking meter another motorist rear-ended him. Petitioner testified that when the vehicle he was driven was hit items on the inside of the van hit him in his shoulder. Petitioner testified that he was hit with pieces of concrete, steel post and actual parking meters. He testified that after the accident, he felt a lot of pain and that the pain was intolerable. He testified that prior to this accident, he had no prior injuries to his neck, back, or right shoulder. Petitioner testified that he was taken by ambulance to Illinois Masonic Hospital for immediate care and treatment.

The August 22, 2008 ambulance report indicates that petitioner was hit in the passenger back (rear) side with minimal damage. (Px #3) The report indicates that petitioner was standing outside of his vehicle and that he complained of low back and right shoulder pain. (Px #3)

While at Illinois Masonic Hospital, petitioner reported that his right hand was bracing the passenger side seat when the collision occurred. (Px #7) He also reported low speed, no head trauma and mild symptoms. (Px #7) A CT scan of the cervical spine was obtained and the findings were unremarkable. The emergency room doctor examined petitioner and diagnosed him with cervical, lumbar and right shoulder sprains. (Id p. 386.) The Petitioner requested that his mother-in-law, Miriam Del Santos be notified of the accident. (Id.) His symptoms were regarded as mild and no x-rays of the right shoulder were obtained as his range of motion was within normal limits. Petitioner has a history of anxiety. He was advised to follow up with his primary care physician.

On August 25, 2008 petitioner was evaluated by Dr. Jayant Sheth at Mercy Works. Petitioner was alert and oriented. (Px #4) During the visit, petitioner refused to be examined,

refused to walk and did not want to move his right shoulder. (Px #4 p.10) Petitioner told Dr. Sheth that he would be examined by Dr. Kruda. (Id.)

According to Dr. Sheth's records, petitioner was referred to an orthopedic and prescribed physical therapy. (Px#2)

On September 29, 2008, Petitioner was evaluated by Dr. Robert Goldberg. (Px#5) Following an examination, Dr. Goldberg recommended an MRI of the right shoulder, lumbar spine and cervical spine. Id. He stated that the Petitioner was off work (Px #5 p.164)

Petitioner denied any prior neck, back or right shoulder pain prior to his MRI on October 8, 2008. (Px # 5 p.190) However, Petitioner had a prior workers' compensation claim that settled for 2% loss of use of a person. At trial, Petitioner voluntarily dismissed claim 08 WC 38359 where is claimed permanent injury to his chest and lungs as the result of an exploding battery. (Px #1)

On October 22, 2008, petitioner underwent the right shoulder MRI, which revealed moderate tendinosis of the intra articular portion of the biceps tendon with a small split tear, and mild tendinosis of infraspinatus. (Px #6 p. 251)

The cervical MRI revealed mild degenerative disc disease at C5-4 and C5-6. There was also mild right paracentral disc bulge at C5-6 and mild right foraminal stenosis at C3-4. (Px #5 p.76)

On October 27, 2008, petitioner was given a steroid injection for his right shoulder pain. (Px #5) Petitioner reported minor relief and continued to complain of right shoulder pain. The next day, Petitioner was complaining of lumbar pain 8/10 at Dr. Goldberg's office. (Px #5 p.230)

On November 24, 2008, Dr. Goldberg recommended right shoulder arthroscopy/debridement and manipulation under anesthesia.

On November 11, 2008, the Petitioner checked in with MercyWorks, but refused to allow the doctors there to examine him. The ambulated within normal limits, but his head was in a rigid position and he held his right arm in a flexed position. Waddell's test was positive for the low back "sensitive with subjective pain to light touch." (Px #4 p.12, 15)

Throughout the course of the Petitioner's physical therapy, he cancelled or "no showed" seven times. No progress was made during this time and the Petitioner continued to complain of lumbar and cervical pain.

On December 22, 2008, Dr. Goldberg wrote that Petitioner's diagnosis was "worsening right shoulder adhesive capsulitis and impingement." This is in contrast with the MRI that stated Petitioner had tendinosis and a small slip tear of the biceps tendon. Dr. Goldberg wrote that his patient needed surgery ASAP.

On January 9, 2009, Petitioner underwent a right shoulder arthroscopy that failed to show any biceps tendon tear. (Px #5 p.75) It was observed to be "normal and intact." There was no evidence of bicep tendon pathology, even with retraction. There were no loose bodies and the rotator cuff was intact. However, there was "abundant bursitis" in the sub acromial space, which required extensive debridement, but no decompression. (Id. p. 76) The post-operative diagnosis continued to state right shoulder impingement syndrome.

On January 26, 2009, the physical therapist noted that the Petitioner needed to "be pushed" through his exercises. Three days later, he had difficult demonstrating the home exercise program to the therapist. (Px #5 p.236) The Petitioner underwent his exercises "very slowly." Id . 234.

The Petitioner underwent post-operative physical therapy and attended 24 visits over the next 14 weeks. (Px #5 p.123) In March, Dr. Goldberg requested 12 additional visits.

On March 19, 2009, Dr. John Obermiller, performing a utilization review, reviewed the Petitioner's medical records and wrote that no additional physical therapy was warranted pursuant to Occupational Disability Guidelines. (Px #5 p.123) Dr. Goldberg was not available to discuss the matter peer-to-peer.

Despite the above, the Petitioner's last physical therapy visit was on April 8, 2009 which shows he had 37 total physical therapy visits. (Px #5 p.134)

Dr. Goldberg recommended that petitioner participate in work conditioning, so an evaluation was performed. On April 27, 2009, Artemio Soto, PT, CEAS at Accelerated Rehabilitation who noted that the Petitioner showed signs of inconsistent performance and as a

result a battery of validity testing was undertaken. It was noted that 14 objective validity criteria were tested in 4 major categories. Mr. Morales failed 13 objective validity criteria. Nevertheless, after speaking with Dr. Goldberg, another week of work conditioning was recommended. (Px #5 p. 104)

Utilization Review physician, Andrew Sebby, disagreed with the additional work hardening and "non-certified" the additional request. The Petitioner had already had 37 physical therapy visits which exceeded Utilization Review guidelines. (Id. p. 110) Dr. Goldberg and the therapist had a lengthy discussion about the Petitioner's noncompliance (Px #5 p.67). Dr. Goldberg spoke with his patient about the same. However, the workers' compensation insurer refused to resume additional work conditioning. (Id.)

On April 29, 2009, the Petitioner underwent a lumbar spine MRI that was normal. (Px #5 p.69) The Petitioner had been complaining of lumbar spine pain since the date of the accident.

On May 11, 2009, Dr. Goldberg placed petitioner at MMI with permanent restrictions of no lifting, pushing, or pulling more than 40 lbs. and no lifting overhead more than 20 lbs. Dr. Goldberg was frustrated by the denial of additional work hardening. (Px #5. p. 68 & 78)

Dr. Goldberg released the petitioner to return to work and advised the petitioner to return to see him when necessary.

Petitioner testified that he has not seen Dr. Goldberg since his release to return to work.

Petitioner testified that he returned to work as a parking meter machinist and that his wage at the time was $23.03 per hour. Petitioner testified that he was transferred to the department of water because his position was eliminated. He testified that his position within the department of water was water meter machinist trainee. He testified that this position required him to place water meters on a tester to test for accuracy. He testified that on or around January 25, 2010 he presented his restrictions to Matt Quinn in the department of water and he was told that the department could no longer accommodate him.

Petitioner testified that prior to starting the trainee program he was sent a job bid announcement for the water meter machinist and several other documents. (Px# 13)

Petitioner testified that once he was told that the department could not accommodate his restrictions he began doing an independent job search. Petitioner testified that he looked for jobs, but he did not bring any of his job searches to trial. He testified that he turned his job searches in to his department on a monthly basis and that he looked for 8-10 jobs per month.

Petitioner testified that in October 3, 2011, he was offered a position as a Watchman at the City of Chicago's Department of Water Management. Petitioner testified that he is currently making $21.13 per hour in his position as watchman. Petitioner testified that his rate of pay has increased from $19.24 to $19.91 to $20.31 to $20.72 to $21.13 since he started in October 3, 2011.

Petitioner testified that he experiences an uncomfortable pain in his right arm occasional and that he experiences pain when it storms or with rain. He testified that he takes Tylenol 3 with codeine and that he has not seem any doctor regarding his pain in more than one year.

Petitioner has a prior settlement which represents a settlement in the amount of 2% loss of use of a person. (Rx#2) The Petitioner did not report this pre-existing injury to his doctors.

Gregory Gill, the district clerk for the City of Chicago, testified that he processes the payroll and time for the City of Chicago. He testified that he processes the time for the water meter machinist and that the current rate of pay is $39.70.

Mr. Gill testified that he has worked for the City of Chicago for four years, which was approximately August 2011. On cross examination, he testified that he processed petitioner's pay as a watchman only and that he never processed his pay as a water meter machinist or water machinist trainee. He testified that he was familiar with the apprenticeship program, but he did not know if petitioner had successfully completed the program or would have successfully completed the program.

Ashley Pak, City of Chicago's Department of Water Management liaison testified that she has worked for the City of Chicago for a total of 19 years. She testified that she was familiar with petitioner because she placed him in the watchman position. Ashley Pak testified that petitioner worked in the water meter trainee program from November 2009 through January 26, 2010, when petitioner presented his restrictions. Ashley Pak testified that petitioner was never a

water meter machinist because he never completed the trainee program. Ms. Pak testified that the water meter trainee position no longer exists and that the program no longer exists. She was unsure of when the program was eliminated.

Ms. Pak testified that Bid announcements are never sent to City of Chicago employees directly. She testified that the Bids are posted in various unions and departments. She testified that petitioner's exhibit #13, page one was a very old bid sent out in April 2009, before petitioner was even offered the training program. She testified that PX#13, page 2 is for a machinist position in the City of Chicago's water department. She testified that pages 3 and 4 [illegible] oner and indicates that petitioner was being transferred to the department of water as a water meter mechanic trainee only.

Ms. Pak testified that the water meter trainee position paid $23.03 per hour.

CONCLUSIONS OF LAW

In regards to (J), "Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator finds:

Petitioner sustained by all accounts a minimal motor vehicle accident which resulted in multiple sprains. Nevertheless, Petitioner's complaints of right shoulder pain persisted. Petitioner refused to allow Dr. Sheth examine him or to make any prognosis or diagnosis soon after the accident.

Petitioner was ultimately diagnosed and treated for right shoulder impingement and adhesive capsulitis because he was so guarded with his care and treatment.

Petitioner underwent arthroscopic surgery and the nature of the surgery was a cleanup. Dr. Goldberg report indicates that there was nothing objectively wrong with petitioner's right shoulder and referred to the synovitis as mild. The Arbitrator is unimpressed with the Petitioner's claimed injury. The EMS and emergency room records consistently indicate that the accident was a low speed, rear-end push with minimal property damage to the vehicle that the Petitioner was driving. Petitioner's immediate care was minor.

Petitioner's post-operative treatment and care was minor. Petitioner's work hardening petitioner's efforts were noted as invalid and inconsistent. Therefore, work conditioning was denied by Respondent. Dr. Goldberg appears to have prescribed permanent restrictions because Respondent would not authorize additional work conditioning. As a result, the permanent restrictions are not based on a true reflection of petitioner's ability, but as an expression of Dr. Goldberg's frustration with Respondent not following his recommendation for additional work hardening. Petitioner exaggerated his lumbar injury. Petitioner exaggerated the nature and extent of his injuries.

In regards to (K), "What temporary benefits are in dispute?" the Arbitrator finds:

The parties have agreed that Respondent paid temporary total benefits from August 26, 2008 to May 18, 2009. This amount is not in dispute and should have resulted in $22,388.56 paid to Petitioner. Respondent paid $22,615.85: resulting in an overpayment of $227.29. No additional benefits should have been paid to Petitioner.

Nevertheless, Respondent then paid maintenance benefits or TTD from January 26, 2010 to October 2, 2011, when it appeared that Respondent could not accommodate the Petitioner's permanent restrictions. However, Respondent incorrectly claimed a credit for $12,670.96 on The Request for Hearing Form when it may have actually paid out $52,292.80 during this time. (RX #2)

Additionally, Respondent then paid temporary partial disability benefits from October 29, 2011 to September 30, 2015, when the Petitioner took the watchman's job which paid $2 less per hour than his old job as a parking meter machinist. However, The Request for Hearing Form claims a credit for $62,237.69 paid to Petitioner, but it appears as though it incorrectly paid $39,550.72 and the dates claimed are incorrect listed by Respondent as well. (RX #2)

In any event, Respondent is not obligated to pay any additional benefits after May 18, 2009 and the total credit allowed is estimated by the Arbitrator to be $92,070.81.

In regards to L, "What is the nature and extent of the injury?", the Arbitrator finds:

The Petitioner suffered a lumbar strain, a cervical bulge and a shoulder injury that resulted in a diagnostic arthroscopic surgery with some shaving for bursitis. As stated earlier in the decision, the Arbitrator is unimpressed with the nature and extent of the Petitioner's injuries for this accident and does not find the permanent restrictions to be based upon reliable evidence. No tears were found anywhere in the right shoulder; Petitioner's lumbar MRI was normal; very little was found wrong with his cervical spine. Petitioner made no valid effort in work hardening. As a result, the weight of the evidence shows that Petitioner exaggerated his injuries to his doctors and employer. Since the Petitioner's permanent restrictions are invalid, there can be no wage differential award. The value of the claim is 5% of a person as a whole of bulging disc and 10% of a person as whole for the right shoulder injury. No permanent injury is found for the lumbar strain. The total award is 15% loss of use of a person as a whole.

In regards to N, "Is Respondent Due A Credit?", the Arbitrator finds:

Respondent paid temporary total disability from August 26, 2008 until May 18, 2009.

As stated earlier in this decision, the Arbitrator does not find the permanent restrictions prescribed by Dr. Goldberg to be credible. Dr. Goldberg based those restrictions on an invalid work hardening evaluation and was influenced by Respondent's refusal to authorize additional treatment. The Petitioner exaggerated his lumbar injury. As a result, The City of Chicago has no further obligation under The Illinois Workers' Compensation Act to pay additional lost time benefits. The Petitioner returned to work at his original job on or about June 3, 2009.

Respondent then incorrectly paid maintenance benefits and temporary partial disability benefits for various date and amounts. The amount of overpayment appears to be $92,070.81, as discussed above.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Blevins,
Petitioner,

vs.

No. 10 WC 41649,
10 WC 41650

Remington Seeds, LLC,
Respondent.

18IWCC0152

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's §8(a) Petition for additional medical expenses. A hearing was held in Peoria before Commissioner Luskin on September 11, 2017. Both parties were represented by counsel and a record was taken.

Petitioner filed two claims against Respondent: 10 WC 41649, alleging a left knee injury from an accident on October 9, 2009, and 10 WC 41650, alleging neck and right shoulder injuries from an accident on July 30, 2008. In April 2010, Petitioner underwent a C5-C7 cervical fusion related to his injuries. Thereafter, he entered into a settlement agreement for both claims, which was approved by the Commission in a Settlement Contract Lump Sum Petition and Order dated May 15, 2012. As part of that settlement, the parties expressly agreed that Petitioner was not waiving his rights to seek payment for future related medical, surgical and hospital expenses under §8(a) of the Act.

At issue now is the need for, and type of, pain management treatment Petitioner now requires for his ongoing neck, shoulder and arm pain which has persisted since the 2012 settlement contract approval.

At the September 11, 2017 review hearing, Petitioner, then 58 years old, testified that at the time he entered into his settlement contract regarding his claims, he was still under the care of pain management physician, Dr. Ji Li, for pain related to his work injuries. Since Petitioner's cervical fusion surgery in 2010, he continues to experience neck pain, radiating up to his head and down into his shoulders and midback. He also experiences right shoulder numbness and frequent headaches. Since his cervical surgery, his treatments have included chiropractic therapy, nerve blocks and cervical injections. Those treatments have afforded him some pain relief. Petitioner currently takes two opioid medications. He believes that since his cervical fusion surgery, his neck has been getting worse.

At the review hearing, Petitioner offered into evidence Dr. Li's records. Since Petitioner's cervical surgery, Dr. Li has diagnosed him with: failed neck syndrome, cervical radiculopathy, neuralgia, cervical disc disease, and chronic pain syndrome. Dr. Li's note dated December 30, 2013 confirmed that Petitioner's overall pain was worsening, and that he was experiencing neck pain radiating into both arms, with tingling. Dr. Li reported that a cervical injection Petitioner received shortly before that date had provided him with 20% pain relief for approximately one month. On March 5, 2014, Dr. Li documented Petitioner's report that his neck and shoulder pain was 7/10. Dr. Li recommended transforaminal epidural steroid injections and continued use of oral pain medications.

On June 1, 2015, Dr. Li reported Petitioner had tried other opioid medications including Norco, Lyrica, Butrans patches and Exalgo, but that none of those were effective in controlling his pain. Dr. Li confirmed that a goal of pain management is to limit the use of opioid medications as much as possible, but he acknowledged there were not many drug choices left which would adequately control Petitioner's pain. Dr. Li allowed that while injections would not cure the condition caused by Petitioner's injury, they would provide him with temporary symptom relief.

Dr. Li's most recent report dated September 5, 2017 reiterated his prior recommendation that Petitioner undergo interventional services to help manage his pain and decrease use of his medications. Dr. Li had been unable to proceed with his recommended treatment because Respondent did not authorize it.

Dr. Li's most recent treatment plan of September 5, 2017 made the following treatment recommendations: (1) a series of two diagnostic bilateral cervical nerve blocks from C2-C7, and if those provided at least 50% pain relief, then radiofrequency ablation to burn off C2-C7 nerve roots, and (2) at least two therapeutic cervical transforaminal epidural steroid injections at C5-6 and C6-7 to reduce the neuropathic/radicular symptoms created by Petitioner's work injury. Dr. Li noted that the relief provided to Petitioner from these treatments would be temporary, not curative, and would need to be repeated over time.

18IWCC0152

Respondent offered into evidence two reports of its Section 12 expert, Dr. Howard Konowitz. Dr. Konowitz examined Petitioner on January 12, 2017 and documented Petitioner's complaints of: central neck pain with radiation to his scalp; right shoulder pain, and right arm numbness with a severe burning and fire sensation. Dr. Konowitz diagnosed Petitioner with cervical headaches triggered with occipital radiation, and mild photosensitivity. Contrary to Dr. Li's diagnosis, Dr. Konowitz expressly found Petitioner did not have cervical radiculopathy. The only treatment Dr. Konowitz recommended for Petitioner was Suboxone treatment, to wean him off prescription opioids.

After reviewing additional medical records, Dr. Konowitz authored a second report dated August 17, 2017. In that report, he disagreed with Dr. Li's recommendation for interventional treatment and injections. Dr. Konowitz believed Petitioner was taking a higher than recommended dose of morphine equivalent medication, and he continued to recommend Suboxone as the only treatment which Petitioner currently needs.

The Commission notes the significant differences between diagnoses and treatment recommendations of Dr. Li and Dr. Konowitz. Between the two, the Commission finds the opinions of Dr. Li more persuasive, as he has been Petitioner's treating physician for over 8 years and is in a better position to evaluate Petitioner's condition and symptoms. Dr. Li's records express not only his awareness, but also his concern that Petitioner's consumption of opioid medications is too high and needs to be reduced. The Commission finds the interventional treatments Dr. Li recommended are necessary to achieve the ultimate goal of decreasing Petitioner's use of narcotic medications.

The Commission does find merit in Dr. Konowitz' recommendation that Petitioner undergo Suboxone treatment to reduce his use of narcotics, and should Petitioner and Dr. Li agree, the Commission finds that treatment would be reasonable and necessary as a result of Petitioner's work injuries. The Commission, however, does not find Suboxone treatment to be the sole treatment Petitioner needs at this time, contrary to Dr. Konowitz' opinion.

Respondent's suggestion that all of Petitioner's prior nerve blocks and injections provided little or no relief is not supported by the record, which shows Petitioner did receive relief from several of those procedures, if only temporarily. Following Petitioner's multi-level bilateral median branch nerve block on January 15, 2016, Dr. Li reported Petitioner had 90% pain relief in his neck for the first five days, and thereafter, about 60% pain relief that lasted about two months.

When the parties entered into their settlement contract and agreed to leave Petitioner's §8(a) medical rights open, they did so with knowledge that Petitioner could require further treatment related to his work injuries.

18IWCC0152

Based upon the above, the Commission finds the following medical treatment recommended by Dr. Li at this time to be reasonable and necessary as a result of Petitioner's work accidents:

- A series of two bilateral (C2-C7) nerve blocks, and
- Two therapeutic cervical transforaminal epidural steroid injections at C5-6 and C6-7.

The Commission further finds that the treatment Dr. Li has provided Petitioner since May 15, 2012, and the medications he has prescribed to Petitioner since that date, have all been reasonable and necessary as a result of his work accidents.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent authorize and pay for a series of two bilateral (C2-C7) nerve blocks, and two therapeutic cervical transforaminal epidural steroid injections at C5-6 and C6-7, as recommended by Dr. Li, pursuant to §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the medical expenses incurred by Petitioner for Dr. Li's treatment and the medications he prescribed since May 15, 2012, pursuant to §8(a) of the Act.

DATED: MAR 15 2018

Joshua D. Luskin

o-01/30/18
jdl/mcp
68

Charles J. DeVriendt

L. Elizabeth Coppoletti

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

Marian Pietrucha,
Petitioner,
vs.

Sonco Real Estate
Respondent.

NO: 16 WC 27520

18IWCC0153

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 21, 2017, is hereby affirmed and adopted.

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

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

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: MAR 16 2018
o030118
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

PIETRUCHA, MARIAN
Employee/Petitioner

Case# **16WC027520**

SONCO REAL ESTATE LLC DEVELOPMENTAL SERIES
Employer/Respondent

18IWCC0153

On 9/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1886 LEAHY EISENBERG & FRAENKEL
GREG LABUZ
33 W MONROE ST SUITE 1100
CHICAGO, IL 60603

0560 WIEDNER & McAULIFFE LTD
JEFFREY SALISBURY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Marian Pietrucha
Employee/Petitioner

Case # 16 WC 27520

v.

Consolidated cases:

Sonco Real Estate, LLC, Development Series
Employer/Respondent

18IWCC0153

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Glaub**, Arbitrator of the Commission, in the city of **Chicago**, on **7/5/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, 7/28/16, Respondent was operating under and subject to the provisions of the Act.

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

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

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 $42,521.96 the average weekly wage was $817.73

On the date of accident, Petitioner was 63 years of age, single with 0 dependent children.

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

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

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

ORDER

Having found the Petitioner failed to prove by a preponderance of evidence that he suffered an accidental injury arising out of and in the course of employment, all benefits are denied.

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

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

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

Signature of Arbitrator

September 20, 2017
Date

ICArbDec19(b)

SEP 21 2017

Marian Pietrucha v. Sonco Real Estate, LLC,

Development Series 16 WC 27520

18IWCC0153

Statement of Facts

Petitioner, Marian Pietrucha, testified through an interpreter. Petitioner testified that he first started working for respondent in September, 2015 and last worked in August (2016). His work week varied anywhere from five to six hours per day, and towards the end of the month could be 10 to 15 hours per day plus weekends. He testified he worked only for Sonco, and identified the owner of the company as Mr. Korol, with a manager by the name of Tomek. It was later established, in English, the name for Tomek would be Tomasz (for the sake of simplicity, this individual will herein after be referred to as Tomasz). Tomasz Mentel also testified as a witness in this matter.

Petitioner testified that Tomasz was a manager, and the one who decides who is going to do what each day and on which construction site petitioner would work. Petitioner's job involved construction, plumbing, carpentry, electrical issues, drywall, cabinets, tiling, flooring, and painting. He was initially paid $18.00 per hour and then received a raise to $20.00 per hour in June (2016). Tomasz told him about the raise.

Petitioner testified that his pay was made by transfer done from an account of Sonco Real Estate, LLC, Development Series into his account. Petitioner testified that Tomasz stated he would talk to (Jack) Korol about the raise. He also testified that he received a seasonal bonus given to him directly by Mr. Korol at the end of the year in an amount of $500.00.

With regard to tools, those were stored in a storage room to which Tomasz and another individual named Artur had access to by key. At the Winona building, the storage room was onsite. Respondent stipulated that the Winona site was owned by Sonco.

The petitioner testified he was provided with T-shirts and a special warming jacket with the logo of the company on the T-shirts and jacket.

With regard to where he would work each day, Tomasz would call every morning. Petitioner testified he did not have the capability to hire any workers on his own because he had no insurance and Tomasz told him it was not necessary.

Petitioner testified that he used to work as a subcontractor and had his own business. That company (P & M Superior Construction, Inc [illegible]e for the purposes of cashing checks for a family member.

Petitioner testified that he injured his shoulder during the course of painting five

apartments when they suddenly ran out of paint. Tomasz went to get additional paint and petitioner was called to unload the truck. While lifting a five gallon bucket, he suddenly felt a jerk that pulled his arm down and then experienced immediate pain in his arm. He knew he was not going to work much longer, so he just went home. Petitioner stated that the following day, a Friday, he reported the injury to Tomasz. He did not see a physician until August 17, 2016, his family doctor, Dr. Forys. Petitioner testified he did not tell Dr. Forys of the accident at work.

Petitioner later went to an emergency room for an X-ray.

Petitioner testified that Jack Korol would come to the worksite where he was working maybe twice a month. When petitioner first started working, he spoke with Tomasz, and had not yet met Mr. Korol. Petitioner testified that his own company was called P & M Superior Construction, Inc. and was incorporated in March, 2008. He ran that business doing construction work for several years before working on any Sonco properties. Petitioner testified that all of his conversations about where he would work were with Tomasz and all of his conversations about what he would do were also with Tomasz. He could not communicate directly with Mr. Korol because Mr. Korol spoke only English. Time sheets for the hours he worked were given to Tomasz. With regard to the T-shirts he was provided, Tomasz gave them to him. He received only two T-shirts.

Petitioner testified that when he first saw Dr. Forys, he did not reference the accident, but "I just told him that something had happened to my arm and that I don't know what it is." Petitioner acknowledged seeing a physician at Community First Medical Center on August 20, 2016 as well as talking with a nurse. He did not talk to them directly, but had a friend who served as an interpreter for him. When asked if he told Dr. Wong that the pain started out of nowhere, petitioner responded: "I told her that, sort of, I told her that I don't know where it came from."

Petitioner testified that he saw Dr. Thomas Poepping on August 31, 2016 and eventually connected his injury to the work incident.

With regard to how he was paid, petitioner acknowledged the payer on the 1099 forms was Sonco Real Estate and the recipient's name was P & M Superior Construction, Inc. Petitioner acknowledged being the owner of that company, and was accordingly the recipient. He had contacted the IRS to obtain an employer identification number in 2008 when he formed P & M Superior Construction.

Petitioner further testified that he worked every day between September, 2015 and August, 2016 with Tomasz. He denied the ability to turn down any project or work that had nothing to do with Tomasz. Only one day did he work anywhere else except with Tomasz when he took one day off to finish a kitchen after having to wait for cabinets to arrive.

Jack Korol testified that he was a member of Sonco Real Estate, LLC Development Series. With regard to the 1099 forms and payments to an entity identified as P & M Superior Construction, Inc., he testified he was not really familiar with Mr. Pietrucha. The payments were for work and projects like painting. He testified he was not knowledgeable about the ownership of P & M Superior Construction, Inc. He did not recall ever formally meeting Mr. Pietrucha,

although he may see him once or twice a month.

Jack Korol testified that Tomasz Mentel also works in a similar capacity (as Mr. Pietrucha) doing rehab construction. Jack Korol denied ever giving a seasonal end of year bonus to Mr. Pietrucha.

With regard to payments made to P & M Superior Construction, Inc., timesheets were provided by Tomasz to determine the amount of payments. Jack Korol testified that Sonco Real Estate, LLC, Development Series had no employees.

Jack Korol testified that shirts with the logo of RentGreat, a separate entity that just does leasing of properties were given to him as a gift, and he in turn gave them to Tomasz as a gift. He had no knowledge what Tomasz did with them. He never instructed Tomasz when workers should or should not wear those shirts.

On cross examination, Jack Korol clarified that RentGreat Apartments and RentGreat.com are assumed names of Sonco Real Estate, but inactive.

With respect to Sonco Real Estate Development Series, that entity is responsible for maintenance and painting and taking care of properties. He denied knowing who hired people to perform those services. He agreed that Tomasz Mentel does projects for Sonco Real Estate Development. Mr. Korol denied knowing how petitioner got a raise from $18.00 to $20.00 (per hour).

With regard to the payments made to P & M Superior Construction, Inc., Mr. Korol testified that payments were made in that manner because of a request by Tomasz. No taxes were withheld from payments made to P & M Superior Construction.

Tomasz Mentel testified that he had an active business named TM Electric and Construction, Inc. He was familiar with Sonco Real Estate and performed services for them at a number of apartment buildings. Part of the services included painting. Mr. Mentel testified that he did not hire Mr. Pietrucha, but called a friend, who told him that petitioner did not have work and was looking for work. He then testified he hired petitioner to work for Sonco, as he (Tomasz) was a manager or supervisor for the project.

He denied that he hired petitioner to work for T M Electric and Construction, Inc.

With regard to the petitioner's testimony about experiencing sudden pain while lifting a 5 gallon bucket of paint off a truck, Mr. Mentel denied it was reported to him on that day. He further testified petitioner did not report the incident to him, but continued working until approximately August 16, 2016. Mr. Mentel saw the petitioner on a daily basis and observed no limitations with regard to the right shoulder.

It was only after an issue developed with regard to possible drinking on the job by Mr. Pietrucha that Mr. Mentel became aware that petitioner was alleging an injury at work, and that discussion would have occurred after August 16, 2016, but he could not remember the exact date.

Mr. Mentel testified that he was also paid by a transfer of money into his account of TM Electric and Construction, and there was no withholding taken out of that. He did now know if he received a 1099 from Sonco and would have to consult his accountant.

Mr. Mentel further clarified that he normally met with Mr. Pietrucha on a daily basis, told him what work needed to be done and that Mr. Pietrucha got most of the supplies from him.

On cross examination, Mr. Mentel testified that he reported to Jack Korol, whom he considered a superior, but did not know if he would be the one deciding about any raise he might receive. With regard to materials for projects, he was aware that Sonco had a store account and sometimes the materials would be paid for directly from the Sonco account, or sometimes he would pay out of his pocket and then get it (from Sonco).

With regard to a determination of where to go and what work to perform, Mr. Mentel testified there was an internet site where one could see requests from the building, written up by a tenant. The internet site was called GreatRent. He confirmed that he gave Mr. Pietrucha a raise, but could not recall exactly when that was. He testified that was approved by Mr. Korol, but could not remember the circumstances of how that happened.

Mr. Mentel further testified that he directed a number of other workers and would meet with them every morning. He would communicate with Jack Korol about what work needed to be done by telephone. On average, he communicated with Mr. Korol maybe two or three times per week.

Further testifying about the hourly rate of pay, Mr. Mentel testified he made that determination and in general everybody started at $18.00 an hour. Mr. Mentel then partially contradicted himself and testified that the initial starting rate and any raise had to be approved by Mr. Korol.

Exhibits offered into evidence included Respondent's Exhibit 1, a Corporate File Detail Report from the Secretary of State of Illinois indicating P & M Superior Construction, Inc. is still active as a corporation with an agent and President named Marian Pietrucha. Respondent's Exhibit 2 was a Corporation File Detail Report from the Secretary of State of Illinois for TM Electric & Construction Inc. with an agent name of Tomasz Mentel. The president's name is also Tomasz Mentel. Consistent with the petitioner's testimony, Petitioner's Exhibit 3 was a letter from the Department of the Treasury, Internal Revenue Service assigning an employer identification number to P & M Superior Construction, Inc. Respondent's Exhibit 4 and 5 were 1099-MISC forms for 2015 and 2016 showing payments made by Sonco Real Estate, LLC Development Series to P & M Superior Construction, Inc.

Records of Dr. Forys were submitted as petitioner's Exhibit No. 9. The progress note of August 17, 2016, fails to reveal any history of injury, consistent with the petitioner's testimony that he did not tell Dr. Forys about an accident at work.

Records of Community First Medical Center were admitted as petitioner's Exhibit No. 8. The note prepared by RN Terry Simone Lorenz at 11:05 a.m. indicates the patient presented to the emergency department complaining of right shoulder pain and limited range of motion for

two weeks. Petitioner denied injury. The resident note of Natalyn Wong, MD, prepared at 10:56 a.m. indicates the petitioner had complained of worsening right shoulder pain for the past three weeks. "Patient says that it started out of nowhere, but it has been getting more difficult to move his right arm because of pain in the shoulder."

The patient care timeline contains an entry on 10:43 by RN Philip George indicating that the patient complained of right shoulder pain, "unable to recall any injuries, onset two weeks . . ." Finally, the provider note by Michael Wawrzyniak prepared at 12:03 p.m. fails to note any history of injury whether at work or otherwise.

Records of G &T Ortho were offered into evidence as petitioner's Exhibit No. 5. Those records revealed that on August 31, 2016, petitioner did give a history of injury of the right shoulder at work on July 28, 2016 while lifting a five gallon bucket of paint. Petitioner was seen by Dr. Poepping, who ordered an MRI study. The MRI study was completed on August 31, 2016 and revealed a complete supraspinatus tendon rupture with retraction 5cm to the level of the glenohumeral joint line. The infraspinatus tendon was also ruptured. Dr. Poepping has recommended surgery for repair of the rotator cuff.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision with respect to (B) the employer/employee relationship, the Arbitrator finds as follows:

There is no one rule that has been or could be adopted to govern all cases where an employer/employee relationship is in dispute. Rather, various factors have been discussed to help determine when a person is an employee. O'Brien vs. Industrial Commission, 48 Ill.2d 304 (1971) and Henry vs. Industrial Commission, 412 Ill. 279 (1952) factors include: "Whether the employer may control the manner in which the person performs the work; whether the employer dictates the person's schedule, whether the employer pays the person hourly; whether the employer withhold income and Social Security taxes from the person's compensation; whether the employer may discharge the person at will; and whether the employer supplies the person with materials and equipment." Roberson vs. Industrial Commission, 225 Ill.2d 159 (207). However, "the right to control" is deemed the most important factor in making the determination. Weir vs. Industrial Commission, 318 Ill.App.3d 1117 (2002). "An independent contractor is defined by the level of control over the manner of work performance." Horowitz vs. Holabird & Root, 212 Ill.2d 1 (2004).

In this case it is clear there was little, if any, direct contact between Jack Korol as a representative of Sonco Real Estate, LLC, Development Series and Marian Pietrucha. Petitioner testified that he was hired by Tomasz Mentel before ever meeting Jack Korol. All communication with regard to petitioner's day to day activity, came from Tomasz Mentel. Uncontradicted testimony on the record establishes that Tomasz Mentel advised petitioner where to work and controlled his schedule. Tomasz Mentel provided petitioner with instructions as to what job to perform on any given day. Tomasz Mentel provided him with two polo shirts and advised when those should be worn to assist in entry of apartments for the purposes of carrying out work activity. Testimony between Jack Korol and Tomasz Mentel was contradictory on the

topic of whether Jack Korol needed to give approval for a raise. Tomasz Mentel's testimony on that issue contradicted itself. At one point, he testified that he controlled that issue, later testifying that he consulted with Mr. Korol.

It is un-contradicted that supplies were provided to petitioner. What was not clearly developed is who was primarily responsible for providing those supplies. The fact they may have been kept on the premises of the apartment complex being rehabbed is not necessarily indicative of an employment relationship. It could have been done out of convenience and Tomasz Mentel testified that he obtained the supplies, although he did have access to a storage room where supplies were kept. Once again, access for the sake of convenience is not a determinative factor. Mr. Mentel testified that at times supplies were obtained when a provider had an account with Sonco, and at other times he obtained the supplies and sought reimbursement from Sonco.

Tomasz Mentel testified that he received pay from Sonco by transfer into the account of TM Electric & Construction. No withholding was taken from that. Mr. Korol testified that petitioner was paid in a similar manner by transfer of money into an account of P & M Superior Construction, Inc., a corporation owned and controlled by petitioner. Although Tomasz Mentel argued that he hired petitioner to work for Sonco, and he was just a manager or supervisor, he also testified that he would speak with Jack Korol by telephone on average only two or three times per week with regard to projects to be performed.

Petitioner clearly testified that he carried on a business of all manner of construction before he began working on properties of Sonco in 2015. It is obvious he had the skills and expertise to carry out assigned duties with minimal supervision. What supervision was provided all came from Tomasz Mentel. Although the manner of pay is confusing and somewhat troubling, no one factor is determinative of the employment relationship. Three possibilities exist. Petitioner could be an independent contractor in his own right. Petitioner could be an employee of T M Electric & Construction, Inc. Petitioner could be an employee of Sonco Real Estate, LLC, Development Series.

After carefully considering all of the testimony, the Arbitrator concludes that Tomasz Mentel was a supervisor for Respondent Sonco Real Estate, LLC Development Series and hired petitioner to work for Respondent. Respondent exercised control over the work schedule and work to be done through Mr. Mentel and paid Petitioner directly into an account he controlled on an hourly wage basis. Petitioner worked solely for Respondent at all times after finishing up a one day project early on in his employment period related to his prior work as an independent contractor. That Mr. Korol could not effectively communicate with Petitioner is of little relevance since Mr. Mentel acted as a supervisor over Petitioner, to carry out the work rehabbing the Winona apartment complex, and Mr. Mentel was able to communicate directly with both Mr. Korol and Petitioner.

In support of the Arbitrator decision with respect (C) did an accident occur that arose out of and in the course of petitioner's employment by respondent, the Arbitrator finds as follows:

Tomasz Mentel testified credibly that he had no knowledge of any work-related injury to

petitioner's right shoulder until after petitioner last worked for respondent on or about August 16, 2016. It was the following day that petitioner reported for treatment with Dr. Forys, and by his own admission, gave no history of injury at work. Petitioner later sought treatment at Community First Medical Center, in the emergency department, but repeatedly failed to offer any history of work-related injury. It was not until August 31, 2016 when he first saw Dr. Poepping that petitioner reported a history of work-related injury. This was more than one month after the alleged injury.

Petitioner testified that he suffered the immediate onset of pain and reported the alleged injury to Tomasz Mentel the following day. Petitioner's testimony is not credible and contradicted by the treatment records of Dr. Forys and Community First Medical Center. Petitioner testified that he had a friend who served as an interpreter for him when he was evaluated at Community First Medical Center. Language was not a barrier to effective communication. Furthermore, it is apparent from a close review of the records from Community First Medical Center that petitioner had at least four opportunities to give a history of injury, and failed to do so on each occasion.

The Arbitrator finds that petitioner failed to prove he suffered an accidental injury which arose out of and in the course of his employment for respondent on July 28, 2016. Having found that petitioner failed to prove he suffered an accidental injury, all benefits are denied. The Arbitrator need not address the other disputed issues of notice, causal connection, prospective medical care, temporary total disability benefits or penalties.

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Lombardo,

Petitioner,

vs. NO: 14 WC 01068

Riverfront Machine Inc.,

Respondent.

18IWCC0154

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical expenses, vocational benefits, 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. 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 26, 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.

18IWCC0154

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 16 2018
o030818
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

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

LOMBARDO, JOHN
Employee/Petitioner

Case# **14WC001068**

RIVERFRONT MACHINE INC
Employer/Respondent

18IWCC0154

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:

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

5001 GAIDO & FINTZEN
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CHICAGO, IL 60602

18IWCC0154

STATE OF ILLINOIS)
) SS
COUNTY OF LA SALLE)

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

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

John Lombardo
Employee/Petitioner

v.

Riverfront Machine Inc.
Employer/Respondent

Case # 14 WC 1068

An *Application for Adjustment 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 **Ottawa**, on **September 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. 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. ☐ Is Petitioner entitled to any prospective medical care?
L. X What temporary benefits are in dispute?
☐ TPD ☐ Maintenance X TTD
M. X Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. X Other **Vocational Rehabilitation**

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FINDINGS

On the date of accident **February 14, 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 **$29,233.36**; the average weekly was **$562.18**.

On the date of accident, Petitioner was **41** years of age, **married** with **0** dependent children.

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

Respondent shall be given a credit of $ for TTD, **$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 PETITIONER FAILED TO PROVE HIS CONDITION OF ILL-BEING WAS CAUSED BY THE WORK ACCIDENT AND DENIES HIS CLAIM FOR MEDICAL BENEFITS, TEMPORARY TOTAL DISABILITY BENEFITS, VOCATIONAL REHABILITATION, PENALTIES AND ATTORNEYS' FEES.

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

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

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

Christine M Day

Signature of Arbitrator

June 23, 2017

Date

IC ArbDec19(b)

JUN 26 2017

18IWCC0154

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Lombardo	)	
Petitioner,	)	
vs.	)	**No. 14 WC 1068**
Riverfront Machine, Inc.	)	
Respondent.	)	
	)	

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing under the provisions of §19b/§8a in Ottawa on September 28, 2016. The parties agree that on February 14, 2013 the petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree petitioner gave notice of the alleged accident within the time limits stated in the Act. They agree petitioner's wage in the year pre-dating the claimed accident was $29,233.36 and his average weekly wage calculated pursuant to §10 was $562.18.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment;
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
3. Whether petitioner is entitled to payment for medical treatment.
4. Whether petitioner is due TTD.
5. Whether penalties and attorneys' fees should be imposed upon respondent.
6. Whether petitioner is entitled to vocational rehabilitation.

STATEMENT OF FACTS

Petitioner began working for respondent on April 13, 2009 as a shear operator. As such, petitioner would take bigger sheets of metal and cut them down to various sizes. The thickness of the sheets of metal varied from one quarter inch to a half inch. The sheets were usually six-foot-wide by eight foot in length. Petitioner would pull out the material with a forklift and place it on the table in front of the shear. Thereafter petitioner would grab the pieces of metal and push them through the shear to be cut.

Prior to February 14, 2013, petitioner denied having problems with his neck or upper extremities and was in good physical condition. He is left-hand dominant.

On February 14, 2013, petitioner was running one shear while a co-worker ran the other. As petitioner went behind the shear to gather the metal that he cut, he walked in between a dumpster and his shear and the co-worker's shear, his co-worker was discarding metal. Petitioner jerked his neck and back in order to avoid getting hit in the head with the discarded metal. Petitiner felt that if he hadn't made the maneuver he would have been seriously hurt.

Immediately afterward, petitioner felt light-headed and discomfort in his neck. He reported the injury to Carol Roger in respondent's human resources. Roger completed an accident report. Petitioner reported to Roger he hurt his neck and back. He continued to work. As the day progressed, petitioner noticed pinching and pain in his neck. The following day petitioner noticed that as he moved his neck he felt electrical sensations through his body.

On February 16, 2013, petitioner bent down to pet his dog. As his dog tried to kiss his face petitioner moved his neck out of the way and felt the same electrical sensation though his body. He continued to work, but was still getting the same electrical sensation in his body. By the 18th or 19th, he was getting sharp pains in his left arm. He walked over to the ambulance service and was escorted to the hospital.

He was taken to St. Margaret's Hospital, where he gave a history of the work accident to the hospital personnel. He advised he was having the electrical sensation and intense pain in his left arm. An EKG was done to insure petitioner was not having a heart attack. He was released to return to work. Petitioner reported to Carol Roger that he still was not feeling well. She sent him to St. Margaret's Occupational Health.

He was first seen at St. Margaret's Occupational Health on February 21, 2013. X-rays were taken, but no specific treatment was rendered at that time. He continued to have the same complaints. He was discharged from Occupational Health. His claim was denied. He therefore went to his primary care doctor, Dr. David Schlagheck.

He first saw Dr. Schlagheck on March 14, 2013. He continued to have the same complaints. Dr. Schlagheck advised petitioner to take it easy. Petitioner continued to work.

Petitioner did not return to Dr. Schlagheck until November 20, 2013. During the time between March 14, 2013 and November 20, 2013, petitioner continued to have the electrical sensations. Additionally, petitioner noticed his legs and feet were going numb. Petitioner had changed jobs to Sunrise Pool Builders by the time he returned to Dr. Schlagheck in November, 2013. He had no new injuries between March and November, 2013. A brain and cervical MRI was ordered as the doctor wanted to rule out Lou Gehrig's disease.

Three days after the MRIs, petitioner received a call from neurosurgeon, Dr. Dinh. Dr. Dinh advised petitioner he needed to seem right away. At the meeting with Dr. Dinh, Dr. Dinh advised petitioner he needed to have surgery immediately or he would be a quadriplegic. Petitioner had the neck surgery by Dr. Dinh at Proctor Hospital on December 20, 2013. He had a three-level cervical fusion.

After the surgery, petitioner still had numbness in his legs and feet, sharp pains in his arm, he could not get an erection and had uncontrollable bowel movements. He had problems with erections before the surgery, but was not sure what was going on.

Petitioner was released to return to work on March 19, 2014 by Dr. Dinh. He followed up with Dr. Dinh about a year post surgery.

He was referred to urologist, Dr. Chung. Dr. Chung prescribed Viagra, which petitioner can't afford to fill.

Petitioner was sent by his attorney to Dr. Robert Eilers. He as seen by Dr. Mark Levin by respondent. He also received a vocational assessment by Edward Pagella.

Petitioner indicated he could not perform his job at Sunrise Pools as he had difficulty lifting. He returned to work at Sunrise Pools after being released by Dr. Dinh. He was told by Sunrise Pools to take it easy. He oversees the jobs now. He reviewed both Dr. Eilers' and Dr. Levin's reports; both doctors agree he should not be doing any heavy lifting. When petitioner saw his personal physician, Dr. Schlagheck, he agreed petitioner should limit his lifting.

Petitioner has done only manual labor all his life. His highest level of education was high school. He expressed an interest in taking course or retraining in order to obtain employment in a different field. Despite his physical issues, petitioner continues to work for Sunrise Pool Builders for financial reasons. Petitioner takes six to eight Vicodin a day. He does not believe he could return to work for respondent as that job required him to lift fifty to a hundred pounds; he does not believe he could lift any greater weight than twenty to thirty pounds. He is making $11 more an hour for Sunrise than he did with respondent.

His medical treatment was paid by his wife's health insurance.

On cross-examination petitioner confirmed he had not taken any steps to find employment outside of Sunrise Pool. He also has not been told by anyone at Sunrise Pool that he would terminated.

Petitioner claimed he vigorously moved his head in order to avoid being struck by the piece of metal at work on February 14, 2013, whereas when he moved his head on February 16, 2013 to avoid being liked by his puppy, it was not that vigorous.

St. Margaret's Hospital Records (PX.1)

On February 19, 2013, petitioner presented himself with complaints of left chest pain and left arm tingling. Petitioner reported that he thought he pinched a nerve due to the fact that when he moves his head or neck the pain shoots down his body. Under initial comments, petitioner had complaints of chronic pain in the left shoulder with forward flexion of his neck. The diagnosis was cervical disc prolapse with radiculopathy.

The February 21, 2013 cervical X-ray showed straightening of the cervical lordosis; suggesting spasm and mild to moderate degenerative disc disease C5-C6 with associated uncovertebral spurring causing neuroforaminal encroachment.

The November 25, 2013 cervical MRI showed moderate degenerative disc and facet joint disease with posterior disc bulging/protrusion with accompanying osteophytes from C4 through C7.

The January 20, 2014 cervical X-ray showed the removal of lamina at C4-C6, reverse cervical lordosis suggesting spasms, loss of anterior intervertebral disc space C5-C6 and right-sided uncovertebral spurring at C5-C6.

Proctor Hospital Records (PX.2)

On December 20, 2013 he was admitted for surgery due to cervical spine stenosis with cord compression. The history provided was that petitioner had a 10-month history of Lhermitte phenomenon every time he looks down. This has progressively worsened to chronic persistent numbness, tingling in left upper extremity and both lower extremities. Over the last two months, petitioner noticed weakness of both extremities and weakness of left hand and arm.

On December 20, 2013 Dr. Dinh performed an expansive cervical laminoplasty at C4, C5, C6, including an Aesculap expand system for cervical spinal stenosis with cord compression, cord edema and myelopathy.

(These records included Dr. Dinh's initial consultation that is also included in Petitioner's Exhibit 5.)

St. Margaret's Occupational Health/Dr. Robert Koogler (PX.3)

Petitioner was first seen on February 21, 2013 with a complaints of left arm tingling and numbness sensation. He states for about two weeks if he turns his neck a certain way and

especially if he hyperextends his neck he gets a numbness and tingling sensation in the left shoulder and arm.

On Tuesday, February 19, 2013, petitioner felt some tightness in his chest with numbness in his left arm. He was worried about a heart attack and went to the emergency room.

The additional history included: "The actual onset of his symptoms was on 02-16-2013 when he felt a sharp electrical tingling sensation in the left neck that went all the way to the left arm when he was petting his dog and he abruptly hyperextended the neck when his dog went to lick his face. The patient feels he may have injured his neck before this and later complete (sic) a report of injury at work. He recalls that he reflexively jerked out of the way of metal that was being thrown by a coworker on 02-14-2013. He does not recall any symptoms with moving out of the way immediately after his reflexive jerking motion to get out of the way on 02-14-2013. Since developing the symptoms on 02-16-2013, he has had intermittent tingling and numbness in the left arm and shoulder."

An X-ray of the cervical spine showed degenerative changes. The diagnosis was radiculopathy associated with neck movements.

Dr. David Schlagheck Medical Records (PX.4)

Petitioner was first seen by Dr. Schlagheck, after February 14, 2013, on March 14, 2013. Dr. Schlagheck stated petitioner's history was somewhat confusing; noting there was a discrepancy between the initial ER visit and Dr. Kugler's initial visit as to the exact timing of the onset of symptomology. Petitioner was adamant it happened at work even though it was denied by workers' compensation. Dr. Schlagheck diagnosed cervical radiculopathy. Dr. Schlagheck could not answer the question of exact timing of symptomology.

Petitioner returned to Dr. Schlagheck on November 20, 2013 due to the pinched nerve in his shoulder. Petitioner reported he also had numbness in legs and feet.

Petitioner returned to Dr. Schlagheck on October 5, 2015 with left arm pain/injury. Diagnosis was chronic pain following surgery. Norco was prescribed as Gabapentin and Ibuprofen were no longer effective.

Dr. Schlagheck authored a July 14, 2016 letter indicated that due to the condition of cervical disc prolapse and radiculopathy is causing difficulty in lifting or doing construction work. Dr. Schlagheck recommended petitioner not do heavy lifting or construction.

Dr. Dzung Dinh (PX.5)

Dr. Dinh's consultation report of December 9, 2013. His history was a 10-month history of L'hermittes phenomenon every time he looks down, which has progressively gotten worse; last two months also noticed weakness in lower extremities and weakness of left hand and arm. Petitioner was still doing heavy construction. He also reported B/B (bowel and bladder) and sexual function still good. The diagnosis was cervical spinal stenosis, cord compression myelopathy and Brown-Sequard syndrome at C6 level of cervical spine cord.

At the March 19, 2014 visit, petitioner reported difficulty with premature ejaculation and maintaining an erection. Dr. Dinh released petitioner to return to work as of March 20, 2014. He was to return in three months.

According to these records, petitioner did not return until January 30, 2015. He was having arm numbness and electric shock down his left arm that lasted two days causing him concern. He also complained of problems maintaining an erection and episodes of bowel incontinence. A MRI was ordered. He was to return if symptoms failed to improve or worsened.

Petitioner did not return until September 23, 2015. He continued to have pain in left ulnar and last two fingers; feet still numb. He also had erectile dysfunction. He was referred to a urologist.

Dr. S. Chung/Illinois Valley Urologic Health Surgeons Records (PX.6)

He was seen by Dr. Chung on October 5, 2015 due to erectile dysfunction. Viagra was prescribed.

10/33 Ambulance Service Bill (PX.7)

Ambulance service bill from February 19, 2013 in the amount of $687.02.

Hospital Radiology Service Bill (PX.8)

Radiology bill of $1,008.00 for services rendered from February 19, 2013 through November 25, 2013.

Associated Anesthesiology Bill (PX.9)

$3,780.00 bill for anesthesia for surgery on December 20, 2013.

Central Illinois Radiological Bill (PX.10)

$149.00 December 20, 2013 radiologist bill.

Dr. Dzung Dinh Bill (PX.11)

Dr. Dinh's bill totaling $7,667.00 for services rendered from December 9, 2013 through September 23, 2015.

Dr. S. Chung/Illinois Valley Urologic Health Surgeons (PX.12)

Dr. Chung's of $226.00 for services rendered on October 5, 2015.

St. Margaret's Hospital Bill (PX13.)

The bill for services rendered from February 19, 2013 through October 5, 2015 totaled $15,160.50.

Proctor Hospital Bill (PX.14)

Hospital bill for services rendered December 20, 2013 through December 22, 2013 is in the amount of $38,728.26.

Prescriptions (PX.15)

The prescriptions total $466.28.

Dr. Robert Eilers September 15, 2014 Evidence Deposition (PX.16)

Dr. Robert Eilers, board certified in physical medicine and rehabilitation, testified in behalf of petitioner. Dr. Eilers examined petitioner on April 17, 2014, at the request of petitioner's attorney (6). In conjunction with his exam of petitioner, Dr. Eilers reviewed medical records and prepared a report of his findings and opinions (6-7).

Dr. Eilers recorded the history that on February 14, 2013, petitioner jerked his neck back in order to avoid being hit by a piece of scrap metal being thrown by a co-worker. He felt

lightheaded so he reported the incident right away. By Friday, February 15, 2013, petitioner felt electric shocks and Lhermitte's- type sign or electric shocks in his lower body causing him to almost drop to his knees. He felt he pulled something in his neck. Petitioner then said on Saturday his dog licked his face and he had the same sort of electric shooting pain. (8-9)

Dr. Eilers noted petitioner has problems with uncontrollable bowel movements, erections and ejaculations. Petitioner had pain in left arm and some weakness; numbness in both legs and feet. Dr. Eilers found petitioner still had a lot of neurologic deficits from his cervical myelopathy. Specifically, Dr. Eilers called it incomplete quadriparesis. Dr. Eilers believed these conditions were permanent. (13-14)

Dr. Eilers believed petitioner was limited to sedentary to light work (15). Dr. Eilers testified that although petitioner had some preexisting degenerative changes, with the hyperextension in his quick movement in the neck, that petitioner said occurred at work, caused the injury (16). This [action] started to cause enlargement and causes compression myelopathy and just continued every time he was moving (16-17). Dr. Eilers testified it swells every time petitioner moved causing additional injury and compression (17). Dr. Eilers believed the three-level fusion was reasonable and necessary and was caused by the work injury as petitioner was in the wrong place at the wrong time (17-18).

On cross-examination, Dr. Eilers explained why the history recorded by Dr. Koogler could be flawed and rationalized the discrepancies between the history provide to Dr. Eilers by the petitioner and the one recorded by Dr. Koogler (22-27). Dr. Eilers also took exception with the treatment rendered by Dr. Schlagheck; specifically, the failure of Dr. Schlagheck to order an MRI when he saw petitioner on March 14, 2013 (29-31).

Dr. Eilers confirmed petitioner did not have MS (35).

Edward F. Pagella Vocational Report of March 2, 2015 & CV (PX.17 & 18)

Edward Pagella, a certified rehabilitation counselor, performed a vocational assessment of petitioner and determined petitioner met the requirements for vocational rehabilitation as provided in the *National Tea* case.

Dr. Mark Levin's CV, October 14, 2014 Report & June 19, 2015 Deposition (RX.1,2,3)

Dr. Levin, board certified orthopedic surgeon, testified via deposition in behalf of respondent. Dr. Levin examined petitioner in respondent behalf on October 20, 2014; reviewed medical records; as well as the November 25, 2013 MRI and cervical X-rays from January 20, 2014 and March 15, 2014. (The only additional information contained in Dr. Levin's report not contained in any other evidence, was petitioner's statement he quit his employment with respondent in October, 2013 and began working for the pool installer.)

Based upon Dr. Levin's examination of petitioner, review of the medical records and diagnostics studies, Dr. Levin diagnosis was cervical myelopathy of the cervical cord. Dr. Levin testified petitioner had appropriate cervical intervention for the cervical cord lesion which occurred from his underlying cervical arthritic changes. (RX.3, p.20)

Dr. Levin concluded that petitioner's condition was caused by a traumatic episode from petitioner's underlying degenerative changes. Dr. Levin opined, that a person with petitioner's small canal and underlying degenerative changes, a certain motion of his neck can cause the compression and neurological spinal condition. (RX.3, pp. 22-23).

Dr. Levin had opined in his October 20, 2014 report the need for treatment was related to his underlying chronic changes in his neck and any neck motion, even the activities of daily living,

gave petitioner potential for cord injury (RX. 2, p.7). Dr. Levin also concluded that given the severe arthritic changes and osteophytes would cause impingement on the accord from any neck activity whether it be flexing or extending when a dog licks him or just twisting his head in daily activities (RX.2, p.6).

Dr. Levin did not believe petitioner could perform medium to heavy job (RX.3, p.24). Dr. Levin believed petitioner could perform the job [at Sunrise Pool] that he was working at the time he examined petitioner on October 20, 2014.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

C. With regard to the issue of whether an accident occurred that arose out of and in the course of petitioner's employment by respondent, the Arbitrator finds the following facts:

Based upon the unrebutted testimony of petitioner, he was involved in a work accident on February 14, 2013 when he jerked his neck in order to avoid a piece of metal being thrown by a co-worker.

F. With regard to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator finds the following:

The Arbitrator finds petitioner failed to prove that his condition of ill-being of cervical myelopathy was the result of the work accident of February 14, 2013.

The Arbitrator took into consideration the history contained in the February 21, 2013 St. Margaret's Occupational Health records, wherein petitioner indicated the onset of symptoms began on "February 16, 2013 when he felt a sharp electrical tingling sensation in the left neck that went all the way to the left arm when he was petting his dog and he abruptly hyperextended the neck when his dog went to lick his face."

Although these records further indicated petitioner may have injured his neck at work on February 14, 2013 when he reflexively jerked out of the way of metal being thrown by a co-worker, he reportedly did not recall any symptoms at that time. However, since February 16, 2013, he has had intermittent tingling and numbness in the left arm and shoulder.

The history contained in the February 21, 2013 records contradict petitioner's testimony that he moved his head vigorously to avoid being struck by the piece of metal on February 14, 2013, but the movement of his head to avoid his puppy licking his face on February 16, 2013, was not vigorous.

The Arbitrator gives no weight to Dr. Eilers' opinion that the work incident of February 14, 2013 caused petitioner's cervical anomaly for which petitioner underwent cervical surgery on December 20, 2013 as it was based upon flawed facts. Dr. Eilers' report and testimony relied upon inaccurate facts. Dr. Eilers understood petitioner jerked his neck on February 14, 2013 to avoid a piece of metal and that by Friday, February 15, 2013, petitioner felt electric shocks and Lhermitte's-type sign or electrical shocks in his lower body causing him to almost drop to his necks. This description of events from February 14, 2013 and February 15, 2013 is not only contrary to the medical records from February and March, 2013, it does not match petitioner's testimony.

The other unreliable fact Dr. Eilers used in reaching his conclusion, was that petitioner's dog only licked petitioner's face on Saturday [February 16, 2013] that caused petitioner to feel

some sort of electric shooting pain. The medical records and petitioner's own testimony confirm there was more involved than just the dog licking petitioner's face when he felt the electric shock on February 16, 2013.

The records from St. Margaret's Hospital on February 19, 2013 also do no support petitioner's claim. On that date, petitioner complained of left chest pain and left arm tingling with shortness of breath for two days. Under comments, petitioner stated: "I think I have a pinched nerve cause when I move my head or my neck it shoots pain down my body. He denied extremity weakness. Most telling was provided under initial comments that [petitioner] complained of *chronic pain* in the left shoulder with forward flexion of his neck. [Emphasis added] There is nothing contained in the records of the work incident. Furthermore, the timing of the complaints symptoms for two days does not correspond with the work accident, but does correspond with the dog incident.

Further questions on the issue of causality were raised by the history contained in Dr. Schlagheck's records from March 14, 2013, which is the next place petitioner went for treatment of his neck condition. At that visit, petitioner was adamant that the onset of the symptomology was on 2:15 (sic) at work. However, Dr. Schlagheck had nothing to offer regarding the exact timing of petitioner's symptomology.

The question of causation is also clouded by the fact petitioner went over eight months without any further treatment of his claimed injury. During that period of time, he continued to perform heavy work for respondent, lifting 50 to 100 pounds, until he quit in October, 2013 to work for Sunrise Pool.

At the time petitioner finally receive treatment for his neck condition from Dr. Schlagheck on November 20, 2013, there was no further discussion of the work accident. At that time, he reported lightning bolt pain from his shoulders; pain into his legs; and numbness in legs, feet and left hand.

When petitioner first saw Dr. Dinh on December 9, 2013 he presented with a tenth-month history of Lhermitte's phenomenon every time he looked down, which had progressively gotten worse. Petitioner noticed weakness in lower extremities and weakness of left hand and arm over the past two months. There was no mention of any work accident.

The Arbitrator finds Dr. Mark Levin's opinion that petitioner's cervical myelopathy of the cervical cord was caused by the underlying cervical arthritic changes and that a certain motion of the neck could have caused the compression and neurological spinal condition, is supported by the evidence.

Although the Arbitrator questions whether petitioner's condition was the result of anything more than the degenerative progressive cervical arthritis, the Arbitrator finds, based upon petitioner's own admission as contained in the medical records from St. Margaret's Hospital Emergency Room, the St. Margaret's Occupational Health and Dr. Schlagheck, that if petitioner sustained any trauma as a result of the claimed work accident of February 14, 2013, the petitioner's intervening accident involving his dog on February 16, 2013, broke the chain of causation.

For all of these reasons, the Arbitrator finds petitioner failed to prove that his ongoing cervical myelopathy that necessitated surgery was caused by the claimed work accident of February 14, 2013.

J. With regard to the issue of medical bills incurred, the Arbitrator finds the following:

As the Arbitrator finds petitioner failed to prove that his cervical myelopathy, and any treatment for same, were caused by the claimed work accident of February 14, 2013, the Arbitrator denies petitioner's claim for medical expenses.

L. With regard to the issue of TTD, the Arbitrator finds the following:

As the Arbitrator finds petitioner failed to prove that his cervical myelopathy and resulting disability were caused by the claimed work accident of February 14, 2013, the Arbitrator denies petitioner's claim for temporary total disability.

M. With regard to the issue of penalties and attorneys' fees, the Arbitrator finds the following:

As the Arbitrator finds petitioner failed to prove that his cervical myelopathy and resulting medical treatment and disability were caused by the claimed work accident of February 14, 2013, the Arbitrator denies petitioner's claim for penalties and attorneys' fees.

O. With regard to the issue of vocational rehabilitation, the Arbitrator finds the following:

As the Arbitrator finds petitioner failed to prove that his cervical myelopathy was caused by the claimed work accident of February 14, 2013, the Arbitrator denies petitioner's claim for vocational rehabilitation.

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

Earl J. Arndt,

Petitioner,

vs. NO: 13 WC 14606

American Messaging,

Respondent.

18IWCC0155

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, 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 17, 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.

18IWCC0155

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 16 2018
o030118
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

ARNDT, EARL J
Employee/Petitioner

Case# **13WC014606**

AMERICAN MESSAGING
Employer/Respondent

18IWCC0155

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

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

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

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN M POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0507 RUSIN & MACIOROWSKI LTD
SAMANTHA SIMS
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
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Earl J. Arndt
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v.

American Messaging
Employer/Respondent

Case # 13 WC 14606

Consolidated cases: N/A

18IWCC0155

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, February 6, 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 as explained *infra*.

In the year preceding the injury, Petitioner earned $70,000.00; the average weekly wage was $1,341.00.

On the date of accident, Petitioner was 40 years of age, *single* with no dependent children.

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

Respondent shall be given a credit of $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

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator awards the prospective medical care in the form of surgery as prescribed by Dr. Singh pursuant to Section 8(a) of the Act.

Penalties & Fees

As explained in the Arbitration Decision Addendum, Petitioner's claim for penalties and attorney's fees is denied.

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

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

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

Signature of Arbitrator

April 3, 2017
Date

APR 5 - 2017

18IWCC0155

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

Earl J. Arndt
Employee/Petitioner

v.

American Messaging
Employer/Respondent

Case # 13 WC 14606

Consolidated cases: N/A

FINDINGS OF FACT

The issues in dispute include causal connection, Petitioner's entitlement to prospective medical care in the form of a discectomy at L4-L5 surgery as ordered by Dr. Singh, and whether Respondent is liable for penalties and fees pursuant to Sections 19(k) and 16 of the Illinois Workers' Compensation Act (Act). Arbitrator's Exhibit[1] ("AX") 1.

Employment & Background

Earl J. Arndt (Petitioner) testified that he was employed as a Network Operating Associate by American Messaging (Respondent). In this position, Petitioner was responsible for maintaining paging, telephone, and switching equipment. He explained that the job required a lot of driving, going up and down stairs, walking around, and lifting paging infrastructure equipment that weighed an average of 30-40 pounds, but could weigh 60-70 pounds (i.e., an amplifier paging transmitter), 80-90 pounds (i.e., a power supply), or hundreds of pounds (i.e., cabinets that housed these equipment pieces). Petitioner explained that he worked on rooftops and in elevator lofts, "IT" rooms, and phone closets to perform his work. While working on any of these equipment pieces, he would either be standing, kneeling or working on ladders. Petitioner explained that he is 6'1 tall and weighs 290 pounds. On the date of accident, he was approximately 6'2 tall weighing 275 pounds.

Accident

The circumstances of Petitioner's accident are not in dispute. AX1. Petitioner testified that on February 6, 2012 his company vehicle was full of amplifiers that were supposed to be repaired by a vendor, but were not yet repaired. Petitioner explained that he was kneeling in the back of the van lifting, turning and moving the amplifiers that weighed 60-70 pounds. While engaged in these activities, he felt a pop followed by immediate sharp pain in his low and mid-back. Petitioner took Ibuprofen and continued working that day with pain. The following day, Petitioner testified that he could not get out of bed and could barely move. He testified that he called in sick to work and reported the incident to his HR person who directed him on what to do next.

Medical Treatment

On February 8, 2012, Petitioner went to the Concentra Medical Center and saw Timothy Boersma, D.O. (Dr. Boersma). PX1 at 6-11. Petitioner reported mid to upper lumbar pain as well as lower thoracic pain. *Id.* He

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Joint exhibits are denominated "JX" with a corresponding number. Exhibits attached to depositions will be further denominated with "(Dep. Ex. _)."

was prescribed medications and referred to an emergency room. *Id.*

Petitioner testified that he drove himself to the Elmhurst Memorial Hospital emergency room after leaving Concentra and had pain radiating into his legs. The emergency room records there indicate that he was complaining of lower back pain radiating into his legs, and had a positive straight leg raising test bilaterally. PX2 at 9-40. An x-ray revealed bilateral facet arthrosis at L3-4, L4-5 and L5-S1. Petitioner underwent a Toradol injection, and was given light duty work restrictions including no lifting over 10 pounds, and limited bending, standing, and walking. *Id.* He was ordered to follow up with the occupational health clinic, and prescribed Flexeril and Lortab. *Id.*

Petitioner testified that he continued to work, but noticed pain in his lower back that occasionally radiated into his buttocks and leg. Petitioner explained that the radiating symptoms varied with his activity.

On February 10, 2012, Petitioner returned to Concentra for follow up with Dr. Boersma. PX1 at 12-16. Petitioner reported no improvement in his symptoms and continued pain in the left lower lumbar region without radiculopathy. *Id.* On physical examination, Dr. Boersma noted that Petitioner was in severe distress secondary to pain as well as positive bilateral straight leg raise testing in both supine and seated positions. *Id.* He recommended continued medications and physical therapy three times a week for two to three weeks. *Id.* Dr. Boersma also continued Petitioner's light duty work restrictions. *Id.*

Petitioner underwent his initial physical therapy evaluation at Concentra on February 15, 2012. PX1 at 30-33. The physical therapy records from February 15 through February 24, 2012 reflect Petitioner's reports of radiating pain. PX1.

On February 17, 2012, Petitioner returned to Dr. Boersma reporting severe pain with some weakness in his left leg. PX1 at 17-21. Dr. Boersma ordered a lumbar MRI. *Id.*

Petitioner underwent the recommended lumbar MRI on February 23, 2012. JX1. The interpreting radiologist noted the following: (1) limited study due to patient body habitus and diffuse spondylitic changes; (2) moderate to severe stenosis at L4-L5 with left paracentral disc protrusion or herniation; (3) moderate stenosis at L2-L3, slightly greater than left midline; and (4) mild stenosis at T12-L1, L3-L4, and L5-S1. *Id.*

When Petitioner returned to Dr. Boersma, he noted that the lumbar MRI showed stenosis and bulging or herniated discs at multiple levels. PX1 at 24-28. Petitioner was diagnosed with lumber disc degeneration and lumbar radiculopathy, and given a referral for a neurosurgical evaluation. *Id.*

Petitioner testified that he continued to undergo physical therapy. The medical records reflect that he underwent physical therapy at Concentra through February 24, 2012. PX1 at 29-41.

On March 9, 2012, Petitioner saw Sean Salehi, M.D. (Dr. Salehi) for an initial neurosurgical consultation. PX3 at 5-6. Dr. Salehi noted Petitioner's report of mid to low back pain after his accident at work, but no radicular pain going down into the leg or paresthesias. *Id.* Petitioner reported some sharp pain in the groin at times, weakness in the right leg while climbing stairs, and significantly increased pain with any activity. *Id.* Dr. Salehi noted that Petitioner had no prior low back injury or treatment. *Id.* He also reviewed Petitioner's MRI, which was significantly limited in image quality, but found a moderate to large foraminal disc herniation at left L4-5 and a disc herniation at T12-L1 with no central canal stenosis secondary to the disc herniation. *Id.* Dr. Salehi diagnosed Petitioner with herniated discs at L4-5 and T12-L1 and ordered continued physical therapy, light duty

work, and medications. *Id.*

Petitioner testified that he then saw Dr. Salehi on a monthly basis. Petitioner underwent additional physical therapy at Advanced Medical Specialists from March 14, 2012 through April 17, 2012. PX3 at 15-32. As reflected in Dr. Salehi's medical records, Petitioner reported radiating pain in physical therapy on March 14, 2012, April 3, 2012, April 10, 2012, April 13, 2012, and April 17, 2012. *Id.*

On April 20, 2012, Dr. Salehi noted Petitioner's report that he had completed a month of physical therapy with slight improvement, but continued pain which he described as an annoyance and discomfort. PX3 at 7. Dr. Salehi maintained Petitioner's light duty work restrictions, recommended a home exercise program, and scheduled a follow up in one month. *Id.* Petitioner testified that his pain varied a lot with physical activity.

On May 18, 2012, Dr. Salehi noted Petitioner's report of continued low back pain as well as lower thoracic and upper lumbar region pain that was somewhat improved. PX3 at 8. Petitioner rated his low back pain at a level of 7 out of 10 and his mid-back pain at a level of 2-3 out of 10. *Id.* He also reported that "he did have 1 fall since his last evaluation. He is unsure exactly why he fell, just said that his legs gave out on him." *Id.* Dr. Salehi recommended facet injections at L4-5, continued light duty and medications. *Id.*

Petitioner testified that he requested a second opinion. He explained that he wanted to look into the recommended facet injections first because anything involving the back and spine was intimidating.

On June 15, 2012, Dr. Salehi continued to recommend 1-2 facet injections at L4-5 as well as continued light duty work. PX3 at 10-11. He also recommended a follow up in one month at which time Petitioner would begin a two-week work conditioning program followed by a functional capacity evaluation to determine any permanent work restrictions. *Id.*

On July 13, 2012, Dr. Salehi noted that Petitioner did not go for the facet injections and was fearful of proceeding with injections in his spine. PX3 at 12. He also noted that Petitioner had not yet had a second opinion as he had been unable to get in touch with his case manager. *Id.* Petitioner testified that the case manager changed and he was not able to get in touch with anyone yet at this point. Dr. Salehi ordered a two-week work conditioning program after which he would undergo a re-evaluation and be returned to work. *Id.*

Section 12 Examination – Dr. Singh

On August 9, 2012, Petitioner saw Kern Singh, M.D. (Dr. Singh) at Respondent's request. PX4 (Dep. Ex. 3). Dr. Singh's report reflects that he took a history from Petitioner, examined him, reviewed various treating medical records, and rendered opinions regarding his physical condition and its relatedness, if any, to his injury at work. *Id.*

Dr. Singh opined that Petitioner "sustained an L4-L5 disc herniation as a result of his work-related injury." PX4 (Dep. Ex. 3). In so concluding, Dr. Singh noted his review of Petitioner's February 23, 2012 MRI films showing "a large, left-sided L4-L5 disc herniation causing lateral recess and foraminal stenosis. There appears to be a disc osteophyte complex at T12-L1 resulting in mild stenosis." *Id.* Dr. Singh indicated that Petitioner's L4-L5 disc herniation was symptomatic and he did not believe that facet injections or epidural injections would provide any long-term relief. *Id.* Instead, he recommended a left sided L4-L5 microscopic discectomy. *Id.*

Continued Medical Treatment

On August 10, 2012, Petitioner returned to Dr. Salehi who noted that Petitioner had not gone through the recommended work conditioning program, but did undergo an independent medical evaluation. PX3 at 13. Dr. Salehi also noted Petitioner's report of low back pain without leg pain. *Id.* Dr. Salehi reiterated his recommendation for work conditioning. *Id.*

Petitioner last saw Dr. Salehi on September 21, 2012. PX3 at 14. Petitioner testified that he was not sure at the time of this visit whether he should do work conditioning, undergo the recommended injections or undergo surgery. He explained that he was not sure what to do because it was all very intimidating. Petitioner testified that he was confused, so he spoke with his primary care physician, Dr. Gabriel, who referred him to Dr. Onibokun. *See also* RX6. On April 10, 2013, Petitioner was seen by Dr. Gabriel who noted that he weighed 325 pounds. RX6.

Petitioner first saw Adebukola Onibokun, M.D. (Dr. Onibokun) on December 6, 2012. PX5 at 10-11. Petitioner reported that he had been in pain since February of 2012 after his injury at work. *Id.* Dr. Onibokun reviewed Petitioner's lumbar MRI noting that it was of poor quality. *Id.* Dr. Onibokun diagnosed Petitioner with low back pain precipitated by a work-related injury and possible L4-L5 neural foraminal stenosis. *Id.* He also ordered a new MRI and EMG/NCV. *Id.*

Petitioner underwent the recommended repeat MRI on December 29, 2012. PX5 at 13-14. The interpreting radiologist noted the following: (1) multilevel degenerative disc disease; (2) right paracentral disc protrusion at T12-L1; (3) disc bulge at L2-3 with mild spinal stenosis and bilateral foraminal stenosis; (4) disc bulge at L3-4 with moderate spinal and bilateral retinal stenosis; and (5) disc bulge and annular tear as well as probable left foraminal disc protrusion at L4-5 causing moderate to severe left foraminal stenosis. *Id.* Petitioner also underwent the recommended EMG on January 8, 2013. PX5 at 21-23. The results showed no evidence of acute right lumbosacral radiculopathy from L2-S1. *Id.*

On January 17, 2013, Dr. Onibokun noted that Petitioner had low back pain and a left L4-L5 posterior lateral lumbar disc herniation with manifested symptoms of left L5 radiculopathy secondary to the herniation. PX5 at 17-20. Dr. Onibokun recommended an epidural steroid injection, physical therapy and light duty.

On February 21, 2013, Petitioner underwent the first recommended injection at L4-L5 with Dr. Onibokun at Elmhurst Memorial Hospital. PX6 at 21-23. Petitioner underwent the second injection at L4-L5 on March 28, 2013. *Id.*, at 39-40. Petitioner testified that he felt about 50% pain relief after the injections, but the relief was not lasting.

Petitioner testified that he was offered a new job with another employer, Verizon, in North Dakota, and began that job in May of 2013. Prior to going to North Dakota, Petitioner hired an attorney to have representation as he was leaving the state. Petitioner testified that his job duties at Verizon include monitoring and "break-fixing" equipment, which are less physical than the job duties of the position he held with Respondent. He also explained that the equipment with which he works is smaller than that with which he worked while employed by Respondent.

In a letter dated October 2, 2013, Petitioner's counsel requested approval for the surgery recommended by Dr. Singh. PX8. In a response letter dated October 8, 2013, Respondent's counsel indicated that no treating physician had recommended the surgery and, as such, the surgery was not authorized. *Id.*

Second Section 12 Examination – Dr. Hartz

On June 28, 2014, Petitioner submitted to a second independent medical evaluation at Respondent's request. RX1. This examination took place in North Dakota with Charles Hartz, M.D. (Dr. Hartz). *Id.* Dr. Hartz performed a physical examination of Petitioner, took a history from Petitioner, noted his review of various treating medical records, and rendered opinions regarding the relatedness, if any, of Petitioner's current condition of ill-being and his accident at work. *Id.*

Petitioner reported low back pain ranging from 2 out of 10 to 7 out of 10, and indicated that he had no pain-free days. RX1. Petitioner also reported that his pain depended on his activities, and he denied leg pain at that time. *Id.* Dr. Hartz noted that Petitioner worked as a telecommunications engineer at the time and he carried less than 10 pounds of supplies, materials or other substances at work. *Id.* While Petitioner had to then-current work restrictions, Petitioner reported that he did obtain help on an as-needed basis. *Id.*

Dr. Hartz diagnosed Petitioner with pre-existing degenerative disc disease with facet arthritis and foraminal stenosis in the lumbar spine, which was temporarily aggravated by the work accident. RX1. Dr. Hartz opined that Petitioner required no further epidural injections, surgery, or physical therapy, but indicated that he would benefit from a home exercise program that could be taught in two physical therapy sessions. *Id.* He placed Petitioner at maximum medical improvement as of his last date of treatment in March of 2013 and indicated that he was capable of working full duty. *Id.*

Petitioner testified that the exam was fairly brief and he understood that Dr. Hartz determined that he only suffered a temporary aggravation of a pre-existing condition.

Continued Medical Treatment

On September 5, 2014, Petitioner underwent his third lumbar MRI at Mercy Hospital in North Dakota. PX7. The interpreting radiologist found multilevel disc disease with bulging disc-osteophyte complex is contributing to mid-lumbar spinal canal stenosis at the L2-L3, L3-L4, and L4-L5 levels. *Id.* He also noted a chronic asymmetric disc herniation paracentrally on the right T12-L1, on the left at L4-L5, and less prominently, bulging centrally contributing at several levels to mid-lumbar spinal canal stenosis. *Id.*

Petitioner then returned to Dr. Singh on December 1, 2014 as a patient. PX4 (Dep. Ex. 4). Dr. Singh examined Petitioner and reviewed his most recent lumbar MRI, which he noted showed an unchanged large left-sided L4-5 foraminal disc herniation compared to the February 23, 2012 MRI. *Id.*; PX4 at 16. He maintained his recommendation for an L4-5 microscopic discectomy. *Id.* Petitioner saw Dr. Singh a second time on August 31, 2015. PX4 (Dep. Ex. 5). Dr. Singh continued to recommend surgery. *Id.* Petitioner testified that he was released to full duty at this time to his work with Verizon, which is within the previous light duty restrictions.

Deposition Testimony – Dr. Singh

On October 1, 2015, Petitioner called Dr. Singh as a witness and he gave testimony at an evidence deposition. PX4. Dr. Singh testified that he is a board certified orthopedic surgeon. PX4 at 4-6; PX4 (Dep. Ex. 1).

Dr. Singh testified that he was retained by Coventry to perform an independent medical evaluation of Petitioner which took place on August 9, 2012. PX4 at 6. He next saw Petitioner on December 1, 2014. *Id.*, at 14-15. Dr. Singh noted that Petitioner had persistent straight leg raise on the left, and negative Waddell findings, and

weakness in the EHL distribution on the left which was consistent with an L5 radiculopathy. *Id.* He also testified that as of Petitioner's last visit with him on August 31, 2015 the recommended surgery had not yet been authorized. *Id.*, at 17.

Dr. Singh opined that Petitioner's current condition of ill-being as of August 31, 2015 was causally related to his accident at work. PX4 at 18-19. He also opined that the recommended surgery was reasonable and necessary to alleviate Petitioner from the effects of his injury at work. *Id.*, at 19.

On cross examination, Dr. Singh testified that he was not aware whether Petitioner underwent other diagnostic testing or treatment between February 2012 and September of 2014. PX4 at 25. He acknowledged that Petitioner was obese, and that Petitioner had been released to work full duty. *Id.*, at 32-33.

Deposition Testimony – Dr. Hartz

Respondent called Dr. Hartz as a witness and he provided testimony at an evidence deposition on July 12, 2016. RX2. Dr. Hartz testified that he is a board certified orthopedic surgeon. RX2 at 4-6. Dr. Hartz maintained that Petitioner's low back complaints were temporarily aggravated by the incident of February 6, 2012. RX2 at 13. Dr. Hartz maintained that Petitioner did not require any further medical treatment and that Petitioner reached maximum medical improvement as of his last medical treatment in March of 2013. *Id.*, at 14-15.

On cross examination, Dr. Hartz acknowledged that the last spine surgery he performed was in the 1990's. RX1 at 17. He also acknowledged that he performs primarily IME's for insurance companies. *Id.*, at 19-20. Dr. Hartz could not recall any plaintiffs' or petitioners' attorneys sending him clients for independent medical evaluations. *Id.*, at 20-21. Dr. Hartz also testified that while Dr. Singh's recommendation for an L4-L5 discectomy may have been appropriate at the time of his recommendation in 2012, he did not believe that Petitioner required that surgery at the time of his evaluation in 2014. *Id.*, at 22-24. Dr. Hartz further acknowledged that he did not review Petitioner's MRI films, only the radiologist's reports, and that he was unaware whether Petitioner had any MRIs subsequent to his evaluation or whether any surgical recommendations were made subsequent to his evaluation. *Id.*, at 25-27.

Additional Information

Regarding current condition, Petitioner testified that he still has the same pain. He continues to experience increasing pain with physical activity. As a result, Petitioner has gained weight and probably deteriorated in health. Petitioner testified that he had not had a pain free day since his accident. He also experiences the radiating pain on a varying basis depending on his physical activity including walking. If he walked or tried biking he would be in pain. Petitioner testified that he would like the pain to go away so that he can continue living, and he wishes to undergo the recommended surgery from Dr. Singh.

ISSUES AND CONCLUSIONS

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

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

The parties' dispute centers on whether Petitioner's low back condition stems solely from degeneration and whether there is objective evidence to support Petitioner's radicular complaints such that the surgery recommended by Dr. Singh is appropriate. After considering the record as a whole, the Arbitrator finds that Petitioner's claimed current condition of ill-being in the lumbar spine is causally related to the injury sustained at work on February 6, 2012.

In determining whether Petitioner's low back condition continues to be causally related to his injury at work, several other facts are relevant. Petitioner had no prior injury to his low back. He had no low back or radiating symptoms into the lower extremities, or corollary medical treatment, before February 6, 2012. Moreover, all of the physicians understood the same mechanism of injury as well as Petitioner's large body habitus. Petitioner then underwent a lumbar MRI on February 23, 2012.

The interpreting radiologist found moderate to severe stenosis at L4-L5 with left paracentral disc protrusion or herniation, moderate stenosis at L2-L3, slightly greater than left midline, and mild stenosis at T12-L1, L3-L4, and L5-S1. Drs. Boersma, Salehi, and Singh independently determined that Petitioner's February 23, 2012 MRI showed herniated discs and stenosis. Dr. Boersma of Concentra found that the MRI showed stenosis and bulging or herniated discs at multiple levels. Dr. Salehi read the MRI to show a moderate to large foraminal disc herniation at left L4-5 and a disc herniation at T12-L1 with no central canal stenosis secondary to the disc herniation. Dr. Singh's interpretation of the MRI films was similar to Dr. Salehi's; he found a large, left-sided L4-L5 disc herniation causing lateral recess and foraminal stenosis and a disc osteophyte complex at T12-L1 resulting in mild stenosis. Dr. Hartz did not review Petitioner's MRI films and, instead, relied on the radiologist's report.

It is notable that Petitioner's first neurosurgeon, Dr. Salehi, did not recommend surgery, but he did believe that Petitioner was in need of invasive medical treatment and he ordered facet injections. Petitioner testified that he was wary of undergoing such injections. He explained that, while he was determining whether to undergo this treatment and looking for a second opinion, the case manager assigned by Respondent's workers' compensation insurance carrier changed. Petitioner testified that he was unable to get a second opinion as requested. Dr. Salehi's records corroborate Petitioner's testimony. No testimony was offered into evidence from any case manager. Moreover, no testimony was offered into evidence from Dr. Salehi or Dr. Boersma. Only two physicians gave testimony regarding Petitioner's need for surgery, if any; Respondent's first Section 12 examiner who later became Petitioner's treating physician, Dr. Singh, and Respondent's second Section 12 examiner, Dr. Hartz.

"Liability cannot be premised upon imagination, speculation or conjecture but must arise from facts established by a preponderance of the evidence." *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill. App. 3d 681, 685 (1st Dist. 1994). Likewise, the lack of liability cannot be premised upon imagination, speculation or conjecture. Some portions of Dr. Salehi's records note Petitioner's denial of lower extremity symptoms. However, Dr. Salehi contemporaneously notes Petitioner's reports of leg weakness and even one occasion when he fell after "his legs gave out on him." No testimony from Dr. Salehi was offered into evidence explaining these inconsistencies. Given that Dr. Salehi did not testify, the record devoid of an explanation for his diagnoses, the cause of Petitioner's need for his recommended treatment, the reasons for the particular treatment recommendations that he made, or whether he would have recommended surgery depending on the outcome of Petitioner's facet injections. In addition, the emergency room records from Elmhurst Memorial Hospital on the

date of accident reflect Petitioner's complaint of lower back pain radiating into his legs as well as objective clinical evidence corroborating his subjective complaint. The emergency room physician noted that Petitioner had a positive straight leg raising test bilaterally. In light of the foregoing, the Arbitrator does not find Dr. Salehi's lack of a surgical recommendation to support the opinions of Dr. Hartz or controvert the opinions of Dr. Singh.

Respondent called Dr. Hartz as a witness and he did provide testimony regarding his examination of Petitioner. Dr. Hartz examined Petitioner on one occasion and issued a report in which he opined that Petitioner required no surgery. He opined that Petitioner only sustained a temporary aggravation of pre-existing degenerative disc disease. At his deposition, Dr. Hartz admitted that he did not personally review any of Petitioner's MRI films. He also admitted that he did not review Dr. Singh's Section 12 report or any of Dr. Singh's subsequent treatment records. Dr. Hartz also admitted, albeit without addressing causation, that a surgical recommendation for an L4-L5 discectomy may have been appropriate at the time of the recommendation in 2012. Based on the foregoing alone, the Arbitrator finds that the opinions of Dr. Hartz are not persuasive. "Expert opinions must be supported by facts and are only as valid as the facts underlying them." *Gross v. Ill. Workers' Comp. Comm'n*, 2011 IL App (4th) 100615WC, *16-17, 960 N.E.2d 587, 594 (4th Dist. 2011) (*citing In re Joseph S.*, 339 Ill. App. 3d 599, 607 (2003)). Dr. Hartz did not have an accurate understanding of Petitioner's medical condition like Dr. Singh, who personally reviewed the initial MRI of February 23, 2012 as well as Petitioner's subsequent MRIs and other treatment records. Moreover, notwithstanding the foregoing deficiencies in Dr. Hartz's analysis, it is also notable that Dr. Hartz last performed spine surgery in the 1990's and he performs medical evaluations primarily for insurance companies. In light of the foregoing, the Arbitrator does not find the opinions of Dr. Hartz to be persuasive and accords them no weight.

The only other surgeon to examine Petitioner or provide medical treatment is Dr. Singh. When he first evaluated Petitioner as a Section 12 examiner for Respondent, he opined that Petitioner sustained a disc herniation at L4-L5 as a result of his work-related injury. He indicated that the herniation was large based on his personal review of Petitioner's February 23, 2012 MRI films. Dr. Singh further indicated that Dr. Salehi's recommendation for injections was unlikely to provide any long-term relief and, instead, he recommended a left sided L4-L5 microscopic discectomy. Dr. Singh's prediction regarding the efficacy of injections is supported by the records of Dr. Onibokun. Those records reflect that the injections administered to Petitioner provided no long-term relief, and Petitioner testified that he felt no long-lasting effects.

Again, unlike Dr. Hartz, Dr. Singh reviewed Petitioner's MRI films from February 23, 2012 as well as the MRI films from Petitioner's September 5, 2014 study. Dr. Singh indicated that Petitioner's most recent MRI showed an unchanged large left-sided L4-5 foraminal disc herniation compared to the February 23, 2012 MRI and he maintained the recommendation for an L4-5 microscopic discectomy. Petitioner had no complaints or medical treatment relative to the low back before his accident at work. He had no treatment to the low back or for radiating symptoms in the lower extremities before the accident. Petitioner also only became symptomatic immediately after his accident with documented constant low back symptoms as well as waxing and waning symptoms in the lower extremities that were clinically correlated. There is simply no evidence in the record that Petitioner's low back condition and its sequelae are due to anything other than the accident at work.

Dr. Singh based his opinions on a more complete understanding of Petitioner's medical condition than Dr. Hartz. In consideration of the totality of the record, the Arbitrator finds the opinions of Dr. Singh to be persuasive and accords them significant weight. Thus, the Arbitrator finds the opinions of Petitioner's treating physician, Dr. Singh, to be persuasive and further finds that Petitioner has established a causal connection between his current condition of ill-being and accident at work.

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

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his accident at work as claimed in reliance on Petitioner's credible testimony as well as the opinion of his treating physician, Dr. Singh. Petitioner's condition has not improved after his accident at work and, as Dr. Singh expected, more conservative treatment modalities such as injections would not provide him with any long-lasting relief. Thus, the Arbitrator awards the recommended prospective medical care in the form of an L4-L5 discectomy as prescribed by Dr. Singh pursuant to Section 8(a) of the Act as this treatment is reasonable and necessary to alleviate Petitioner from the effects of his injury at work.

In support of the Arbitrator's decision relating to Issue (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

Section 19(k) of the Act provides in pertinent part:

> In case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay. 820 ILCS 305/19(k) (Lexis 2011).

Section 16 of the Act provides for an award of attorney fees where an employer, its agent, service company or insurance carrier:

> ... has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of the provisions of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier.

820 ILCS 305/16 (Lexis 2011).

After a review of the record as a whole, the Arbitrator finds that additional compensation should not be imposed upon the Respondent pursuant to Sections 19(k) and 16 of the Act. In so concluding, the Illinois Appellate Court's decision in *Hollywood Casino* is instructive. *Hollywood Casino-Aurora, Inc. v. Ill. Workers' Comp. Comm'n*, 2012 IL App (2d) 110426WC, 967 N.E.2d 848, 2012 Ill. App. LEXIS 187, 359 Ill. Dec. 818 (2nd Dist. 2012). While the Arbitrator is cognizant of the dissent in the Court's decision, there is no "...requirement that an employer authorize medical treatment for an injured employee in advanced of the services being rendered[, and] the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving that authorization." *Id.*, at *P19.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laurie A. Bohne,
Petitioner,

vs. NO: 14 WC 34535

Sycamore Healthcare Centre,
Respondent.

18IWCC0156

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 April 27, 2017, is hereby affirmed and adopted.

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

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

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: MAR 16 2018
o030818
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BOHNE, LAURIE A
Employee/Petitioner

Case# **14WC034535**

SYCAMORE HEALTHCARE CENTRE
Employer/Respondent

18IWCC0156

On 4/27/2017, 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 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:

2427 KANOSKI BRESNEY
THOMAS R EWICK
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

2674 BRADY CONNOLLY & MASUDA PC
NOAH P HAMANN
211 LANDMARK DR SUITE C2
NORMAL, IL 61761

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

☐ 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

Laurie A. Bohne
Employee/Petitioner

v.

Sycamore Healthcare Centre
Employer/Respondent

Case # **14** WC **34535**

Consolidated cases: **N/A**

18IWCC0156

An *Application for Adjustment 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 **February 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 **11/15/13**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$48,172.80**; the average weekly wage was **$926.40**.

On the date of accident, Petitioner was **45** 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 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** for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of **$247.52** to Quincy Medical Group as provided in Sections 8(a) and 8.2 of the Act.

Petitioner failed to prove that her current condition of ill-being in her right knee is causally related to her accident of November 15, 2013. Petitioner sustained, at most, a strain/sprain of her right knee and failed to prove that her condition of ill-being in her right knee as of March 4, 2014 was causally connected to her accident. No other 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

April 23, 2017
Date

APR 27 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

On/about July 9, 2013 Petitioner underwent a general orientation with Respondent during which time she was given written information pertaining to the reporting of incidents. (RX 1)

On November 18, 2013, Petitioner presented to the office of Dr. Batra regarding right knee pain and swelling. According to the doctor's notes Petitioner had originally injured her knee at home one month earlier and it was healing when she re-injured it at work on Friday. Petitioner provided additional details indicating that she had been moving a refrigerator at home one month earlier and it was healing until she re-injured it at work on Friday when she had to lift a 330 pound patient. Petitioner was primarily complaining of knee pain and swelling. She complained of pain when rising from a seated position and ascending or descending stairs. Dr. Batra's examination of the right knee noted pain with movement, small effusion, anterior swelling, and overall tenderness, including the patella, lateral and medial joint lines. Flexion was normal but extension was abnormal. Dr. Batra diagnosed a knee sprain. She recommended ice, an ace wrap and oral nonsteroidal anti-inflammatory drugs (NSAIDS) to help with pain and selling. Dr. Batra also referred Petitioner to physical therapy. (PX 1; PX 2, pp. 75 - 78)

On November 25, 2013, Petitioner called Dr. Batra's office and indicated she did not want to start physical therapy. Dr. Batra cancelled the physical therapy order. (PX 2, p. 74)

Petitioner voluntarily stopped working for Respondent on December 30, 2013. (RX 3)

In January of 2014 Petitioner applied for a job with The Good Samaritan Home of Quincy and she completed an application. According to it, Petitioner had never been injured while working for Respondent. She also affirmatively stated she could lift fifty (50) lbs. and denied any knee or joint problems. (RX10)

Petitioner returned to Dr. Batra on February 10, 2014 for several concerns; however, none of them included knee complaints. (PX 2, pp. 70 - 73)

On March 4, 2014, Petitioner again presented to Dr. Batra with complaints of ongoing right knee pain. Dr. Batra wrote "No new injury has been working out and doing stairs." Dr. Batra noted that Petitioner had initially injured her knee in the previous year when she had lifted a patient at work and was treated conservatively with ice, ace wrap and oral NSAIDS but continued to have symptoms. Petitioner complained of intermittent pain to the medial knee as well as swelling. Dr. Batra ordered an MRI. (PX 2, pp. 66-69)

After her appointment Petitioner telephoned Dr. Batra's office noting she had forgotten to ask the doctor if she could get something for pain when needed. She was given a script for Lortab as she already had Mobic. (PX 2, pp. 64-65)

On March 10, 2014, Petitioner underwent an MRI of her right knee. It showed: (1) tri-compartment osteoarthritis greatest in the medial compartment with associated cartilage abnormalities; (2) a tear of the posterior horn of the medial meniscus; (3) knee joint effusion; and (4) a partial tear of the popliteus along the musculotendinous junction. (PX 3)

Following the MRI, Dr. Batra referred Petitioner to Dr. Adam Derhake, an orthopedic surgeon.

Petitioner completed a Quincy Medical Group questionnaire on March 17, 2014 prior to being examined by Dr. Derhake. Petitioner was asked to explain how her problem started and she marked "injury" and "accident" and gave an onset date of "11/2013." She added "Lifting/Running upstairs." She emphasized that stairs were very problematic. Petitioner further represented that she did not intend to apply for workers' compensation. (PX 2, p. 97)

According to Dr. Derhake's March 17, 2014 office note, Petitioner reported working at a nursing home. She further stated that she had injured her knee in November when she was lifting a resident that weighed nearly 300 pounds and felt some sudden pain in her right knee. She specifically denied feeling a pop at the time. Since that time, she had experienced an occasional pop or click as well as swelling and she reported trying to treat her knee with anti-inflammatories, rest, and activity modification. Dr. Derhake diagnosed a complex posterior horn medial meniscal tear and recommended surgery. (PX 2, pp. 60-62)

Petitioner telephoned Dr. Derhake's office on March 18, 2014 noting she would need four weeks off for her knee surgery. She indicated she would call in the future to schedule an appointment for pre-operative clearance. (PX 2, p. 58)

On April 21, 2014 Petitioner telephoned Dr. Derhake's office requesting that surgery be scheduled. (PX 2, p. 54) She saw the doctor that same date and they discussed the procedure. Petitioner reported having similar complaints of knee pain and symptoms and that they had been progressing and making it more difficult for her to perform activities of daily living. Petitioner was cleared for surgery. (PX 2, pp. 50-53; PX 5)

Petitioner returned to see Dr. Derhake the next day, April 22nd, due to increased pain in her right knee described as "horrible" and requesting work restrictions until her surgery. She was taken off work pending surgery. (PX 2, pp. 46 – 49; PX 6) Later that same day Petitioner called requesting that her surgery be moved up to the current week (April 24th). (PX 2, p. 44)

On April 24, 2014, Dr. Derhake operated, performing a right knee arthroscopy with partial medial meniscectomy and a chondroplasty of the medial femoral condyle and patella. His post-operative diagnoses were a right knee complex posterior horn medial meniscal tear and diffuse grade II chondromalacia changes of medial femoral condyle and the apex of the patella. (PX 4; PX 5)

On April 25, 2014, Dr. Derhake examined Petitioner one day post-op, noting she was doing well. He referred Petitioner for 4 weeks of physical therapy. That same day, she presented for a physical therapy evaluation and treatment. Petitioner gave a history of injuring her knee in November of 2013 when she was transferring a non-responsive patient at work and twisted her knee. She further explained that her knee was painful and swollen but she didn't see a doctor for a while, thinking it was just a strain. She further reported that "over time the knee would improve, but the swelling would come back and started to interfere with work." (PX, pp. 39-41)

On May 7, 2014, Petitioner was seen by Dr. Derhake's certified nurse practitioner, Matthew Bruns, for suture removal. Petitioner reported she was doing quite well with very little discomfort although she "from time to time" noticed a "mild twinge." Otherwise, she had been outside gardening and doing different things in her yard and tolerating it all quite well. She described her level of pain as "2/10." Petitioner's knee had some mild swelling and mild palpable tenderness around the right medial joint line but unlimited range of motion. She was given a workability report to return to work on May 13, 2014 with no restrictions. It was recommended that she return to Dr. Derhake two weeks later for further evaluation. (PX 2, pp. 27 - 29; PX 6)

Petitioner did not return to Dr. Derhake's office for her right knee.

Petitioner did return to Dr. Batra's office on June 17, 2014 but only voiced headache complaints. No right knee problems or concerns were noted. (PX 2, pp. 21 – 24)

Petitioner presented to Dr. Batra's office on July 9, 2014 regarding personal health concerns unrelated to this claim. Multiple stressors in her life were noted, including work. No right knee problems or concerns were noted. (PX 2, pp. 17 – 21)

Petitioner again presented to Dr. Batra's office on July 22, 2014 regarding personal health issues unrelated to this claim. No right knee problems or concerns were noted. (PX 2, pp. 13 – 16) She followed up with the doctor on July 25, 2014. Again, no right knee problems or concerns were noted. (PX 2, pp. 8 – 11)

In a Nursing Encounter form dated August 2, 2014 the therapist noted that Petitioner had been referred for physical therapy in April of 2014 and had attended two out of eight scheduled appointments before discontinuing physical therapy services on her own. She had been given a Home Exercise Program to be done 2-3 times per day. (PX 2, p. 5)

On September 2, 2014 Petitioner received a letter from Tricare acknowledging receipt of the Third Party Liability form regarding her work-related injury. Related information was relayed to Petitioner within the letter. (PX 9)

On October 1, 2014 Petitioner signed her Application for Adjustment of Claim in this matter alleging an accident date of October 20, 2013, when she twisted her right knee while transferring a patient. (RX 5)

On October 1, 2014 Petitioner's attorney wrote to Respondent enclosing a copy of the Application for Adjustment of Claim filed by it in regard to a workers' compensation claim. (RX 4) On October 16, 2014 Respondent completed a "Notice of New Claim" indicating an attorney

letter and First Report of Injury was being forwarded and that the claim was questionable. The First Report of Injury completed by Jonni Bullington was not dated and contained no information regarding the alleged accident. (RX 4)

On May 4, 2015 Dr. Michael J. Milne issued a records review report to Respondent's attorney. Based upon his review of medical records furnished to him, Dr. Milne concluded that Petitioner was suffering from right knee medial femoral condyle and patellofemoral chondromalacia and a complex tear of the posterior horn of her medial meniscus. Dr. Milne was of the further opinion that Petitioner's injury most likely occurred one month earlier than her work injury when she was "lifting a refrigerator at home." He felt the medial meniscus tear, per the MRI report, was consistent with chronic changes. While he acknowledged that the accident at work may have aggravated her symptoms he didn't believe that any structural change in her knee occurred as a result of the injury. He noted no formal accident report or evaluation was done at that time and absent medical records showing an acute exacerbation for those symptoms he felt the work accident was a temporary aggravation of her symptoms and that she would have required the same treatment being offered by Dr. Batra and Dr. Derhake regardless of the accident. Dr. Milne was also of the opinion that Dr. Derhake provided Petitioner with reasonable expectations and that he was reticent to offer her surgery and his surgical findings showed less arthritis than he anticipated. Consequently, he was not surprised that she had done fairly well after her surgery. Dr. Milne further opined that Petitioner would have needed the surgery regardless of the accident at work as it was related to longer standing changes. (RX 6)

In September of 2015 Petitioner returned to Dr. Derhake's office only this time it was for left knee problems. Dr. Derhake initially examined her on September 14, 2015. He noted Petitioner had "done great" with her right knee procedure but she was now starting to have pain and symptoms in her left knee, gradual in onset. On exam her right knee had excellent full range of motion. (RX 9) On September 29, 2015 she underwent a left knee arthroscopy due to a complex posterior horn medial meniscal tear and grade II – III chondromalacial changes of the medial femoral condyle. (RX 8) In the Operative Report Dr. Derhake noted that Petitioner had experienced excellent results after her right knee surgery in 2014. (RX 8) Petitioner continued to treat with Dr. Derhake post-surgery. As of October 28, 2015 Petitioner was still having some problems which the doctor felt was due, in part, to her underlying osteoarthritis. Petitioner denied any specific incident or re-injury to her knee and she had not yet returned to work. She was given an injection for the ongoing knee complaints which, according to the office visit of November 11, 2015, helped out tremendously with any residual pain complaints. She was to return to work in two weeks. She ultimately returned to work on November 25, 2015. (RX 9)

Dr. Derhake, who is board certified in orthopedic surgery and sports medicine, testified by way of evidence deposition taken on August 11, 2016. He testified that the findings of his physical examination which he performed when he first saw Petitioner on March 17, 2014 were consistent with the findings of the MRI. He recommended surgery because Petitioner's pain or symptoms were secondary to a meniscal tear. The meniscal cartilage has an extremely poor blood supply. Without blood supply, the cartilage cannot heal. On April 24, 2014, he performed a medial meniscectomy on the medial meniscus as well as a chondroplasty of the femoral condyle. (PX 7, pp. 9-12)

Dr. Derhake was asked to assume that on November 18, 2013, Petitioner saw Dr. Batra and complained of right knee pain and swelling and had reported that she had initially injured her knee at home almost one month prior while moving a refrigerator but her knee was healing and getting better until she re-injured it on the Friday before the November 18, 2013 office visit with Dr. Batra while lifting a 330 pound patient at work. He was asked to further assume Petitioner underwent no treatment following the refrigerator incident and that her knee was getting better and doing fine before the incident shortly prior to November 18, 2013 where she was lifting a 330 pound patient at work. Dr. Derhake was also asked to assume that while lifting the patient, Petitioner twisted her right knee and felt the sudden onset of pain. Finally, he was asked to assume that she returned to Dr. Batra on March 4, 2014, at which time Dr. Batra ordered the right knee MRI. Assuming those facts to be true and considering his medical records, Dr. Derhake testified the mechanism of injury involving the patient at work in November certainly could have caused the complex posterior horn medial meniscal tear which he observed during surgery. (PX 7, pp. 14-17) He also testified that the work accident could have aggravated the symptoms related to chondromalacia. (PX. 7, p. 17) The following exchange occurred:

> Q. With respect to the, moving back now with respect to the complex posterior horn medial meniscus, meniscal tear which you conclude or which you state could have been aggravated by the incident at work, what do you base that opinion on?
>
> A. Based on the mechanism of her injury, the description of her symptoms, and the correlation of that with her physical exam and MRI.
>
> Q. And when you say mechanism of injury what are you referring to?
>
> A. The description of her twisting her knee and feeling a pop is a very common story or history that patients describe when they initially injure their knee and suffer a meniscal tear. (PX 7, pp. 16-17)

On cross-examination, Dr. Derhake testified that as far as the refrigerator incident and the work accident, he could not state within a reasonable degree of medical certainly which incident caused the meniscus tear. Both incidents, by history, could do so. (PX 7, p. 19) When asked if Petitioner's tear was an age appropriate degenerative tear, Dr. Derhake responded that he believed it seemed more like an acute-on-chronic injury. (PX 7, p. 21) His surgical findings for the left knee which he subsequently treated were similar to those of the right, but he still believed Petitioner's right knee injury was likely an acute-on-chronic injury. (PX 7, pp. 22-23) Dr. Derhake explained that a person who sustains a similar injury will have pain with activities that involve loading weight on the knee and deep flexion, such as kneeling or squatting, and some patients have pain with walking up and down stairs. (PX 7, p. 25)

On redirect examination, Dr. Derhake testified either incident could have caused the meniscal tear. He further testified that twisting the knee while lifting a patient is consistent with a meniscal tear injury and could have caused Petitioner's meniscus tear. (PX 7, p. 29) He also added that Petitioner could have had an asymptomatic meniscus tear which was re-aggravated based on the mechanism of injury she described with lifting the patient. (PX 7, p. 30)

On re-cross-examination, Dr. Derhake was asked to assume the tear was present after the refrigerator incident but was asymptomatic. He was asked whether he could state within a

reasonable degree of medical certainty that lifting the patient aggravated the meniscus. He stated the mechanism of injury of loading the joint and causing a torque or twisting movement on the joint could have either caused or aggravated a meniscal tear. (PX 7, p. 31)

The deposition of Dr. Milne was taken on August 15, 2016. (RX 7) Dr. Milne is a board certified orthopedic surgeon who specializes in knee and shoulder injuries. Dr. Milne testified consistent with his earlier written report. Dr. Milne was asked if Petitioner's right knee condition related to her alleged work accident and he replied that he had no reason to dispute the fact that she hurt her knee while lifting a 300 lb. patient; however, he felt the findings at the time of surgery related to chronic changes and that no structural change occurred in her knee as a result of the work injury. He further testified that based upon his review of the operative report Petitioner had complex/macerated chronic tearing of the posterior horn of the medial meniscus and nothing acute. Had she undergone an MRI five minutes before the accident, he believed the same findings would have been present. As a result he was of the opinion that Petitioner's need for surgery was not due to the work accident. The MRI findings and operative findings were inconsistent with an acute injury. (RX 7, pp. 11 – 14)

On cross-examination Dr. Milne acknowledged that he didn't meet with, or examine, Petitioner. He also acknowledged stating in his report that he felt Petitioner most likely injured her knee a month before her alleged work accident while lifting a refrigerator at home. He further acknowledged that he was now stating that she probably had the chronic changes seen in her knee even before that accident at home. (RX 7, pp. 14 – 18) He admitted that he didn't know if she twisted her knee with the refrigerator. He did not know anything about the size of the refrigerator or whether she was lifting it alone or being assisted.

On cross-examination, Dr. Milne stated he does not know whether Petitioner twisted her knee when moving the refrigerator or how much it weighed. He does not know its size or whether she was lifting it with another person. He admitted Petitioner did not require any treatment after the incident with the refrigerator. He does not know whether following this incident Petitioner experienced pain, swelling, popping, or clicking. (RX 7, pp. 17-22) Dr. Milne admitted that Petitioner could have had chronic changes in her knee but was asymptomatic prior to the incident with the refrigerator or the incident at work where she lifted a 330 pound patient. Either incident could have resulted in an acute-on-chronic type of injury. Either incident could have rendered her chronic changes in the right knee symptomatic. (RX 7, pp. 23-25)

On January 31, 2017 Petitioner filed an Amended Application for Adjustment of Claim alleging an accident date of November 15, 2013. (AX 2)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on February 23, 2017. The disputed issues were accident, causal connection, medical bills, temporary total disability benefits, and the nature and extent of Petitioner's injury. Respondent's representative at the hearing was Jonni Bullington. Witnesses testifying at the hearing were Petitioner, Ashley Kelley, and Jonni Bullington.

Testimony of Ashley Kelley

Ashley Kelley testified on behalf of Petitioner. Ms. Kelley was an employee of Respondent on the alleged date of accident. At that time, she worked as a registered nurse and the director of nursing. She was one of Petitioner's direct supervisors. Ms. Kelley worked for Respondent from October of 2004 through July of 2014.

Ms. Kelley testified that she did not have a social relationship with Petitioner, aside from being Facebook friends. They did not socialize outside of work. She denied having any discussions with Petitioner about the case.

Ms. Kelley testified that at some time in November of 2013 there was an emergency involving an obese patient. Ms. Kelley could not recall the exact date. She recalled that she and Petitioner were in the basement of the building when the code went off. They proceeded to run up the stairs to the patient's room to provide assistance. Ms. Kelley further testified that she left the patient's room to obtain a glucose machine while Petitioner tended to the patient.

After the patient was stabilized, Ms. Kelley did not recall Petitioner making any complaints about her knee that day, but at some point (which Ms. Kelley believed was within two weeks from the alleged date of accident) Petitioner did report knee pain and she believed that Petitioner thought it possibly occurred while she helped the resident on the alleged date of accident.

Ms. Kelley testified that prior to the alleged date of accident, Petitioner never appeared to walk with a limp, nor did she make any complaints of knee pain. She further believed that Petitioner was able to run to Petitioner's room on the date of the occurrence without limping.

Ms. Kelley further testified that when Petitioner did report knee pain, approximately two weeks after the alleged date of accident, someone (she could not recall who) did recommend that Petitioner complete an accident report, but Petitioner never did to Ms. Kelley's knowledge. Ms. Kelley recalled that another nurse was with them at the time it was recommended.

On cross-examination Ms. Kelley testified that she did not witness any accident or injury on November 15th. She also stated that at no point did Petitioner definitively tell Ms. Kelley that she had been hurt at work.

Ms. Kelley was not aware of any other injuries involving Petitioner's right knee outside of the work place.

Ms. Kelley could not recall whether or not Petitioner walked normally or with a limp between the alleged November 15, 2013 date of accident and when she first noticed Petitioner limping.

Ms. Kelley testified that she did recall seeing Petitioner on the date of accident after the emergency situation with the patient was resolved. She did not recall Petitioner walking with a limp at that time.

Ms. Kelley testified concerning general accident reporting procedures for Respondent. She testified that after an injury occurs, the injury is reported by an employee to the employee's

supervisor. An incident report is completed and the facility administrator, who was Jonni Bullington, is notified. There is also a 1-800 # to be called.

Ms. Kelley testified that, generally, if in her role as a supervisor, she felt an employee had been injured at work, but the employee did not want to report the incident, she possibly would have advised the facility administrator about the employee's injury.

Ms. Kelley testified that during her time with Respondent, other employees were injured at work and that Respondent took care of those injured workers.

Ms. Kelley testified that between the alleged November 15, 2013 accident and the remainder of 2013, Petitioner was physically able to perform her job and Ms. Kelley did not observe any deficits or performance issues because of Petitioner's knee.

Ms. Kelley testified that aside from the one conversation she had with Petitioner approximately two weeks after the date of accident about knee pain, there were no other conversations about an accident, injury or knee pain.

On re-direct examination Ms. Kelley testified that there are times at work when employees sustain bumps, bruises or sprains/strains and those incidents were not always reported.

During re-cross-examination Ms. Kelley testified that for incidents where an employee may elect not to report a work injury, if she had observed such an employee having any difficulties performing their job, she definitely would have reported the incident to her direct supervisor.

Testimony of Petitioner

Petitioner testified that on November 15, 2013 she was an employee of Respondent working as a registered nurse coordinator and was in charge of all nurses and CNAs and making sure patients were well cared for. She was hired in July of 2013. Petitioner testified that Ms. Kelley was the Director of Nursing and Ms. Bullington was the Administrator.

Petitioner testified that in October of 2013 there was an incident at her home that involved moving a freezer/refrigerator. She attempted to push a new freezer/refrigerator through a door frame into her house using her knee to help push and, afterwards, her right knee was sore. She denied twisting her knee during the refrigerator moving incident nor she did feel any pops, cricking or clicking sensations. She estimated that that refrigerator incident occurred in mid to late October of 2013. She testified that after the refrigerator incident, she did not seek any immediate medical treatment. She testified that her knee was sore and that she could treat it with over-the-counter medication. She denied any swelling, clicking, limping, or popping after the refrigerator incident.

Petitioner next described the alleged November 15, 2013 accident. Petitioner testified that she responded to an emergency situation involving a patient who was coding. She responded to an unconscious patient who weighed over 200 pounds. With the help of an unidentified certified nursing assistant, the patient was picked up and laid on the floor. During that maneuver

Petitioner stated that she twisted her right knee. She noticed pain while taking care of the patient. She heard a pop. She testified that after the incident she could walk, but it was painful.

According to Petitioner, on the date of the accident, Jonni Bullington commented that she observed Petitioner appearing to be in pain and wondered what was wrong with her to which Petitioner replied that she had hurt her knee. Petitioner further testified that between November 15th and November 18th she was in severe pain and it hurt to walk or do anything. She further testified that her knee was swollen during that time.

Petitioner testified that either Jonni Bullington or Ashley Kelley asked her to complete an incident report, but she declined, hoping that her condition would improve.

Petitioner testified that on November 18, 2013 she presented to her family doctor, Dr. Batra, for her complaints of knee pain which was diagnosed as a knee sprain. Dr. Batra recommended physical therapy and over-the-counter medications. Petitioner also testified that she did not ask Dr. Batra to bill the November treatment to workers' compensation because she thought she could take care of it herself.

Petitioner testified that after seeing Dr. Batra she saw Ms. Bullington in the parking lot and Ms. Bullington inquired how her doctor's appointment had gone. Petitioner testified that she told Ms. Bullington that she had only sustained a strain and Ms. Bullington was pleased.

Petitioner testified that on December 29, 2013 she quit working for Respondent because she was working long hours and the schedule was exhausting.

Petitioner testified that between November 18, 2013 and March 4, 2014 everything about her knee gradually worsened and she felt constant popping. While working for Respondent through December 29, 2013 she did so without any restrictions but was in pain.

Petitioner testified that in 2014 she resumed right knee treatment with Dr. Batra and ultimately underwent right knee surgery. Petitioner testified that at no point did she tell any of her doctors to bill workers' compensation. Her medical treatment was paid by her husband's group health insurance carrier, Tricare. In September of 2014 Petitioner received a letter from Tricare, which was marked as Petitioner's Exhibit 9. The letter stated that any claims related to a work injury would be denied unless a denial letter from Workers' Compensation was received. (PX9). Petitioner testified that upon receipt of that correspondence, she retained an attorney and an Application for Benefits was filed.

Petitioner acknowledged that she didn't undergo any physical therapy in 2013 as she was working a lot of hours and she felt, as a nurse, she could self-treat. She indicated that subsequent to the November 18, 2013 visit with Dr. Batra her right knee pain worsened. It was swollen and there was constant popping. Dr. Batra ordered an MRI, prescribed a knee brace and referred Petitioner to orthopedic surgeon Dr. Derhake.

Petitioner testified to seeing Dr. Batra in February of 2014 and again on March 4, 2014. At the March visit, she sought care for her knee as she was dragging her foot at work and it was very painful.

Dr. Derhake first began treating Petitioner on March 17, 2014. She described the alleged work accident to Dr. Derhake, but she did not tell him about the refrigerator incident. Petitioner testified that she did not disclose the refrigerator incident because she only attributed her problems to the work accident. Petitioner testified that she told Dr. Batra about both incidents.

Ultimately, Dr. Derhake performed a right knee surgery on April 24, 2014. She had four weeks of therapy. Petitioner was released to full duty work by Dr. Derhake on May 13, 2014. Petitioner testified that she has not seen Dr. Derhake for the right knee since May 7, 2014. When Petitioner was off work following her April 2014 surgery, she did not receive any TTD benefits.

Petitioner stated that she was never examined by Dr. Michael Milne, Respondent's Section 12 physician.

Petitioner testified that she currently remains cautious when walking up and down stairs with regard to her right knee. She takes one stair at a time. She will occasionally take over-the-counter medication in part for her right knee pain which she notices a couple of times a week. She describes a dull pain in her right knee. She testified that before the alleged work accident she enjoyed mushroom hunting and fishing, but that those activities are decreased, in part, because of ongoing right knee symptoms. Petitioner also acknowledged having problems with her left knee and Achilles tendon.

Petitioner testified that when she was hired by Good Samaritan Nursing Home in January 2014 she was not required to take any pre-employment physical. She acknowledged in a pre-employment form to being able to perform the required duties at Good Samaritan Nursing Home.

On cross-examination Petitioner admitted that she was trained on how to report work accidents when she was hired by Respondent. As part of the work injury reporting procedure, petitioner testified that ultimately facility administrator Jonni Bullington would be made aware of any accidents or injuries. Petitioner testified that she did not report the incident to Ms. Bullington because she "figured that Jonni knew," because Ms. Bullington was present when the alleged accident took place. However, she never directly reported an accident to her.

Petitioner testified that she quit without giving any notice to Respondent on December 29, 2013. Prior to quitting, between November 15, 2013 and her last day on December 29, 2013, she was able to perform her job full duty for Respondent. During that time Petitioner worked approximately 48 hours per week. She testified that her job duties involved standing for 60% to 70% of her day and daily lifting of up to 75 pounds. Respondent's facility had two flights of stairs. She testified that prior to the accident she walked up and down those stairs every morning, but subsequent to the accident she took the elevator.

Aside from the November 18, 2013 visit with Dr. Batra, Petitioner admitted that she did not see any medical providers for right knee pain until March of 2014.

Petitioner was questioned about the refrigerator lifting incident. Petitioner testified that after the refrigerator incident, she was able to run up and down stairs and she felt that the

refrigerator incident caused only bruising. She described that her knee didn't hurt, but it was "whimpy pain" that bothered her every once in a while.

Petitioner acknowledged that when she had a surgery recommendation in March of 2014, she still had not reported the accident to Respondent. Over the course of Petitioner's treatment she estimated that she paid a little over $600.00 in out-of-pocket co-pays. When Petitioner was off work following right knee surgery from April 27, 2014 to May 12, 2014, she was unpaid and did not receive any TTD benefits. Petitioner agreed that Respondent did not receive any notice of Petitioner's alleged injuries until Petitioner retained an attorney and filed a workers' compensation case in October of 2014. Prior to reporting the incident, Petitioner did receive medical bills and Explanations of Benefits from providers and her husband's group health insurance carrier.

On cross-examination Petitioner again denied that when she was hired by Good Samaritan a physical exam was performed. Petitioner was then confronted with Respondent's Exhibit 10, a pre-hire questionnaire that was completed by Petitioner on January 14, 2014 when she applied for work at Good Samaritan. Petitioner admitted that she did execute the document and that the responses on the document are accurate. She testified that she didn't recall the exam. Specifically, Petitioner affirmed that she did not have any workers' compensation injuries prior to being hired in January 2014 by Good Samaritan, although Petitioner testified that she answered that question because she had never filed a workers' compensation injury before. On the questionnaire Petitioner also affirmed that she was not having any knee problems when she was hired in January 2014. Finally, when Petitioner applied at Good Samaritan she specifically affirmed that she was capable of working full duty.

Petitioner testified that subsequent to being hired by Good Samaritan in January 2014, she worked full duty until April 27, 2014. However, she testified that she hardly did any lifting as there was plenty of staff. Petitioner estimated that she was required to be on her feet fifty percent of the day.

Petitioner's attorney conducted a re-direct examination. Petitioner testified that after the alleged date of accident she did not use the stairs for Respondent. She took the elevator. Petitioner also re-affirmed on re-direct examination that she did tell Dr. Batra on November 18, 2013 about the alleged work accident.

Testimony of Jonni Bullington

Jonni Bullington testified on behalf of Respondent. She is the facility administrator. As such, she was not Petitioner's direct supervisor but, rather, everybody's supervisor as she was at the top of Respondent's leadership pyramid.

Ms. Bullington confirmed that Petitioner resigned in late December 2013 without giving any notice. Ms. Bullington further testified that she did not receive any notice of Petitioner's alleged work injury until Petitioner's Application was sent by Petitioner's attorney in October of 2014.

Ms. Bullington generally described the workplace injury reporting procedure for Respondent. She testified that in general when an individual is hurt, they report it to their direct supervisor. An employee is instructed to complete an incident report and call the 24/7 nurse hot line. That documentation is then given to Ms. Bullington.

Ms. Bullington testified that when a work incident occurs, she would normally undertake an investigation such as talking with witnesses, taking witness reports, and helping the employee obtain medical treatment if necessary.

In this instance, Ms. Bullington testified that she was unable to perform her normal investigation because she did not receive notice until October 2014.

Between November 15, 2013 and the date when Petitioner stopped working for Respondent in late December 2013 Ms. Bullington estimated that she had an opportunity to see Petitioner at least once per day. At no point during that time period did Ms. Bullington observe Petitioner to appear to be in pain. Ms. Bullington denied that she ever observed Petitioner limping at work or that she ever recalled a conversation with Petitioner concerning a limp. Likewise, Ms. Bullington denied that she ever had a conversation with Petitioner in the parking lot subsequent to Petitioner's November 2013 examination with Dr. Batra.

Ms. Bullington testified that she was in the patient's room on November 15, 2013 when the patient was coding, but that she does not remember any injury to Petitioner.

Ms. Bullington was cross-examined by petitioner's counsel. She agreed that Petitioner's job duties involve lifting patients from time-to-time for Respondent and that lifting could involve using an employee's legs. Ms. Bullington also testified that from time-to-time nurses would sustain sprains, strains or bruises.

During Petitioner's employment with Respondent, Ms. Bullington was unaware of any discipline incidents, including reprimands, involving Petitioner. Petitioner was a good worker according to Ms. Bullington.

Ms. Bullington testified that completing the Form 45 was the extent of the investigation she performed into Petitioner's allegations. She did not interview any nurses.

Ms. Bullington testified that she would have no basis to dispute any of the histories reflected in Petitioner's medical records.

Ms. Bullington testified that Ms. Kelley was one of Petitioner's supervisors on the date of accident.

Respondent's counsel performed a re-direct examination of Ms. Bullington. Ms. Bullington was asked when she first became aware that Petitioner was specifically alleging that she had been hurt at work transferring a patient who had coded on the toilet. Ms. Bullington testified that she became aware of Petitioner's specific accident details well after receiving the initial correspondence from Petitioner's attorney, marked as Respondent's Exhibit 5. The Application

received by Ms. Bullington in October of 2014 states that Petitioner twisted her knee while transferring a resident, but there were no other details on the Application. (RX5).

Upon receipt of the Application in October of 2014, Ms. Bullington testified that the supervisors who would have been involved in that incident were no longer employed by Respondent. Ms. Bullington claims that she attempted to track down some CNAs who might have been on duty or to find out what resident or residents would have been involved in Petitioner's alleged accident.

Respondent's Exhibit No. 2 documents Petitioner's work hours and pay for pay checks issued between July 25, 2013 and January 9, 2014. It reflects that before and after the November 15, 2013 incident, Petitioner consistently worked 80 hours every two weeks and also consistently worked overtime. (RX 2)

Petitioner's medical bills are found in PX 8.

The Arbitrator concludes:

With respect to issue (C), did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner sustained an accident on November 15, 2013 that arose out of and in the course of her employment with Respondent. Ashley Kelley testified that within two weeks of the alleged date of accident, Petitioner complained of knee pain and stated that she thought her pain was possibly related to the claimed November 15, 2013 incident. Ms. Kelley was with Petitioner on November 15, 2013 when they responded to the emergency call. While she did not witness the lifting episode because she left the patient's room to get equipment she took no issue with Petitioner's description of the circumstances. No evidence was presented suggesting that Petitioner was not in the course of her employment or that her accident arose out of her employment. Petitioner was on duty at the time of the accident and engaged in an activity the employer might reasonably have expected her to perform.

Issue E: Was timely notice of the accident given to the respondent?

Petitioner gave timely oral notice of the accident to Respondent

Oral notice is sufficient under Section 6(c) of the Act. The fact that Petitioner did not complete a written report, even if contrary to the policy of Respondent, does not circumvent the notice requirements as set forth in Section 6(c).

As noted above, Ashley Kelley testified that within two weeks of the accident involving the resident, Petitioner complained that her knee was hurting and said that it possibly occurred while helping that resident. In fact, Ms. Kelley testified another nurse suggested Petitioner complete an accident report but Petitioner chose not to complete one. Ms. Kelley's testimony was not contradicted at trial. At the time of the accident, Ms. Kelley was the Director of Nursing for Respondent, and Petitioner's direct supervisor. Notice to Ms. Kelley was sufficient notice to Respondent given her role with Respondent.

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

Petitioner failed to prove that her current condition of ill-being in her right knee is causally related to the November 15, 2013 accident. The Arbitrator finds that Petitioner, at most, sustained only a right knee sprain/strain as a result of the November 15, 2013 accident. The Arbitrator bases her decision on evidence suggesting Petitioner's injury was not as significant as Petitioner might have tried to establish, Petitioner's lack of corroboration for certain critical aspects of her testimony, Petitioner's statements in the Quincy Medical Group questionnaire of 3/14/14 and Dr. Derhake's unpersuasive opinion on causal connection.

Evidence suggesting that Petitioner's accident of November 15, 2013 was not that significant includes the fact that Petitioner did not fill out an accident report at that time, although given the opportunity to do so, because she did not think the accident was that significant, that she lost no time from work, that she denied the opportunity to participate in physical therapy, and that she sought no further treatment for her knee between November 18, 2013 and March 4, 2014. Finally, she denied any injuries while working for Respondent when applying for a job with Good Samaritan Home in January of 2014. Indeed, it does not appear that Petitioner really considered her right knee to be a work-related problem until her spouse's insurance carrier contacted her about a form she had completed which had caused it to question if she had a work injury. Petitioner did not submit the information she supplied to TriCare as part of her exhibits. Therefore, what, if any, representations she made to it are unknown.

Petitioner initially treated on November 18, 2013 following the accident and was diagnosed with a sprain. Thereafter she did not treat again for her right knee until March 4, 2014. While the doctor recommended Petitioner try therapy on November 18, 2013, she cancelled the therapy request on November 25, 2013 and never underwent any therapy. Additionally, when Petitioner left employment with Respondent on December 29, 2013, she was immediately hired by Good Samaritan in January 2014. When she applied at Good Samaritan, she specifically affirmed that she had healthy knees and that she was fit for full duty work. This evidence, coupled with the lack of treatment until March 2014, strongly suggests that Petitioner returned to baseline following the November 15, 2013 accident or, at a minimum, her knee had resolved enough that she needed no further treatment for any acute problem.

In order to find a causal connection between Petitioner's accident and her right knee condition upon resumption of medical care in March of 2014 the Arbitrator must find Dr. Derhake's causation opinion to be persuasive and credible. In order to so find, one must also find the hypothetical set of facts upon which his opinion was based to be accurate and complete. The Arbitrator is unable to do so. She must also find Petitioner's testimony regarding the details of the accident and her ongoing symptoms post-accident to be credible. She is unable to do that either.

At the arbitration hearing Petitioner testified that she both twisted her right knee and felt a pop when she lifted a heavy patient on November 15, 2013. Except for one isolated reference to twisting her knee (given when presenting for physical therapy on April 25, 2014) Petitioner's medical records fail to corroborate her testimony. Dr. Batra's records of November 18, 2013, February 10, 2014 and March 4, 2014 contain no mention of a twist or pop. When seen by Dr.

Derhake on March 17, 2014 Petitioner did not mention any twist at the time of the accident and his notes specifically state that she denied hearing a pop. Furthermore, the questionnaire she completed at Quincy Medical Group on March 17, 2014 associates her knee problem with "lifting/stairs." Petitioner did not testify to injuring her knee on November 15, 2013 on stairs. Petitioner also testified that when she saw Dr. Derhake on March 4, 2014 she was dragging her foot at work. Yet, there is no mention of such a symptom in his office notes and the Arbitrator believes that since Petitioner is a nurse she would have known the significance and importance of such a complaint and would have mentioned it to the doctor if, indeed, she was experiencing it.

Further troubling is the chronology of events between November 15, 2013 and March 4, 2014 which Dr. Derhake was unaware of within the context of the hypothetical facts presented to him. The hypothetical suggests that Petitioner twisted her knee on November 15, 2013 and thereafter she saw Dr. Batra on November 18, 2013 and then returned to see him on March 4, 2014 at which time an MRI was ordered. That is not an accurate overview of the facts as the doctor was unaware of the following: (1) that on November 18, 2013 Petitioner was diagnosed with a knee sprain; (2) that Petitioner chose to not pursue the therapy recommended to her at that time; (3) that Petitioner continued to work full duty for Respondent until December 29, 2013; (4) that Petitioner sought further employment after December 29, 2013 and represented having no knee injuries; (5) that Petitioner had no knee complaints when seen by Dr. Batra on February 10, 2014; and (6) that Petitioner reported to Dr. Batra on March 4, 2014 that she was working out and doing stairs, and experiencing intermittent pain and swelling in her knee. As such the hypothetical posed to the doctor was incomplete and, in turn, his opinion less persuasive.

Dr. Derhake also testified that if Petitioner had been injured at work as she alleges, she would have experienced daily pain and limitations at work because of her knee. (PX7, pp. 25-26) The evidence shows that Petitioner was able to work full duty for both Respondent and Good Samaritan Home subsequent to the work accident, which again suggests a minor strain that resolved quickly.

The evidence in the record also suggests that Petitioner was having problems with her right knee before the work accident herein. Upon resuming medical care in March of 2014 Petitioner did not necessarily describe her symptoms to the doctor as being continuous and unending since her work accident; rather, she described complaints of knee pain, swelling, clicking and popping as occasional and intermittent in nature. Petitioner had lost weight during the four month gap in treatment (PX 2) and when presenting to the doctor in March of 2014 she specifically referenced working out and "doing stairs." By her own representation to the therapist on April 25, 2014 Petitioner stated that her knee would improve but the swelling would come back and start to interfere with work. This is the same type of history noted on November 18, 2013 when Petitioner told the doctor she had injured/hurt her knee at home and it was "improving" but then she injured it at work. In this instance the Arbitrator is unable to conclude that Petitioner's accident of November 15, 2013 remained "a cause" of her ongoing symptoms and complaints and, in turn, her need for surgery in 2014. She failed to meet her burden of proof on the issue of causation as Dr. Derhake's causation opinion, based upon hypothetical facts, was not accurate and complete. The doctor, quite simply, did not have the full picture.

Finally, the Arbitrator cannot overlook that Petitioner subsequently returned to Dr. Derhake for similar complaints in her left knee, including a medial meniscus tear, and that none of that treatment stemmed from a work accident.

For all of these reasons, the Arbitrator finds that Petitioner sustained only a temporary sprain/strain to her right knee as a result of the November 15, 2013 accident. Petitioner has not met her burden of proof to prove a causal connection between the alleged accident and a right knee meniscus tear requiring surgery.

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

Having found that Petitioner only sustained a temporary knee strain as a result of the alleged work accident, Petitioner is awarded the medical bill for Petitioner's November 18, 2013 visit to Dr. Batra. All subsequent treatment pertains to Petitioner's meniscus tear, liability for which is denied on a lack of causation.

Issue K: What temporary benefits are in dispute?

Consistent with her causation determination, Petitioner's request for an award of temporary total disability benefits is denied.

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

Given her causation determination, this issue is moot. Petitioner failed to prove she sustained any permanent partial disability to her right knee as a result of her November 15, 2013 strain/sprain.

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16WC29744
Page 1 of 3

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

Robert Carlile,
Petitioner,

vs.

NO: 16 WC 29744

Hiltz Propane Systems, Inc,
Respondent.

18IWCC0157

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, temporary total disability, causal connection, medical expenses, notice, credit and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 10, 2017, is hereby affirmed and adopted.

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

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

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

18IWCC0157

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $29,100.00. 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: MAR 16 2018
o030118
DLG/mw
045

David L. Gore

Stephen Mathis

Dissent

I respectfully dissent from the Decision of the majority. I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain his burden of proving he sustained a work-related accident, and denied compensation.

The Arbitrator found Petitioner to be a credible witness and based his decision on that determination. Unlike an Appellate Court, the Commission acts as a primary finder of fact, and is in the same position to determine the credibility of witnesses as the Arbitrator. In my opinion, the credibility of Petitioner is the primary issue on which to determine compensability in this claim, where the alleged accident was not witnessed or specifically corroborated. Also in my opinion, Petitioner was inherently not credible. His testimony was internally inconsistent and contradicted by the record as a whole.

Petitioner testified that on the date of the alleged accident, he was loading a paving machine onto his truck. As he bent over to tie down the load, he "heard and felt a pop" in his back, his "legs went out from under" him, he fell down on the trailer, and "off the trailer on the ground." He testified the fall to the ground was seven to eight feet and he landed directly on his knees. However, when he reported the accident to his dispatcher immediately after the incident, at the emergency department on the day of the accident, in his employee report of accident executed about a week later, and even in his Application for Adjustment of Claim, Petitioner never mentioned any fall. In addition, there was no report of any injury, or even bruising, to his knees either at the emergency department or any time thereafter. Finally, Petitioner had significant pre-existing degenerative disc disease, the natural progression of which could explain Petitioner's current condition of ill-being. That was the opinion of Respondent's Section 12 medical examiner. It also appears that Petitioner was less than forthcoming about his pre-existing condition to his treating physician, who testified he could find no other "plausible explanation" for Petitioner's condition other than his alleged injury.

18IWCC0157

In addition, Petitioner's credibility is put into question because of his apparent drug-seeking behavior. He sought narcotic pain medication from different doctors. He acknowledged that when a particular doctor refused to prescribe such medication, he obtained Percocet and Vicodin from people he knew who were not medical providers. Petitioner also acknowledged that various of his treating doctors encouraged him to wean off narcotic pain medication. In fact, when the Arbitrator awarded prospective treatment, he "urged" Petitioner "to cease the use of narcotic medications," as well as to lose weight and stop smoking, as recommended by his treating doctor. There is no stigma for somebody to become dependent on narcotic pain medication. Nevertheless, such dependence becomes a powerful incentive for patients and claimants to pattern their testimony and or reports to medical providers in order to obtain such medication.

Based on the reasoning stated above, I would have found that Petitioner did not sustain his burden of proving he sustained a compensable accident. Therefore, I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain his burden of proving he sustained a work-related accident, and denied compensation. For these reasons, I respectfully dissent.

Deborah L. Simpson

RWW/dw
O-10/12/17

Deborah L. Simpson

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

CARLILE, ROBERT
Employee/Petitioner

Case# **16WC029744**

HILTZ PROPANE SYSTEMS INC
Employer/Respondent

18IWCC0157

On 8/10/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

5983 CARAWAY FISHER & BROOMBAUGH PC
JASON R CARAWAY
9423 W MAIN ST
BELLEVILLE, IL 62223

5074 QUINTAIROS PRIETO WOOD & BOYER
DANA BENEDETTI
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

R Carlile v. Hiltz Propane Systems, Inc. , 16 WC 029744

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

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

Robert Carlile
Employee/Petitioner
v.
Hiltz Propane Systems, Inc.
Employer/Respondent

Case # 16 WC 029744

18IWCC0157

An *Application for Adjustment 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 **4/13/17 and 6/12/17** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **6/13/16**, 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 **$32,055.00**; the average weekly wage was **$1,282.20**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$12,435.57** for TTD, **$0** for TPD, **$0** for maintenance, and **$2,937.04 (PPD Advance)** for other benefits, for a total credit of **$15,372.61**.

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 $854.80/week for 51 6/7 weeks, commencing 6/14/16 through 6/12/17, as provided in Section 8(b) of the Act.**

Respondent shall pay **reasonable and necessary medical services**, pursuant to the medical fee schedule, **of the bills listed in Petitioner's Exhibits 9-16, as provided in Sections 8(a) and 8.2 of the Act.** Respondent is entitled to a credit for all bills that it has paid.

Respondent shall authorize and pay for the MRI spectroscopy and CT discogram at L3-4, L4-5 and L5-S1, as ordered by Dr. Matthew Gornet on February 13, 2017, along with all related services.

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

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

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

Signature of Arbitrator

August 9, 2017
Date

ICArbDec19(b)

AUG 10 2017

FINDINGS OF FACT

Petitioner was employed by Respondent as a truck driver, driving oversized loads. Petitioner began his employment with Respondent on December 21, 2015. Petitioner's job duties consisted of transporting 60,000 and 90,000 gallon propane tanks, in addition to other heavy machinery. Petitioner was responsible for securing the loads, lifting and throwing chains and tarps, tying down straps, and driving 600 miles a day. Petitioner passed a DOT physical to begin employment with Respondent. It is undisputed that Petitioner was working full duty, without physical restrictions, at the time of the alleged accident.

Prior to his employment with Respondent, Petitioner worked for Little Caesar's Pizza. Petitioner's job duties at Little Caesar's required him to drive a fifty-three foot trailer loaded with product to multiple stores. Petitioner also was tasked with manually unloading the product. Some of the product, such as flour, weighed fifty pounds per bag. Petitioner testified he routinely delivered 12 bags at a time into a store. Petitioner testified he was able to do this job without restriction or pain.

Petitioner testified on direct examination about a emergency room visit which occurred on August 27, 2006, nearly ten years prior to the alleged accident. Petitioner said that he had gone to Crossroads Community Hospital in Mt. Vernon, Illinois on that date. He was camping with his family at Rend Lake and had slept in a tent. Petitioner testified he had not slept in a tent for years and later went to pick up an empty cooler and pulled a muscle in his back. Petitioner testified he went to the emergency room and, "got a shot in the butt". It does appear that Petitioner was given an injection at this ER visit and he responded well. (PX 1) Petitioner did not follow up with any doctor after this incident. When asked why he did not follow up, despite the emergency room physician's recommendation to do so, Petitioner testified, "I was good. My back was fine. I was back to work. Everything was good."

There was no evidence of any other treatment regarding Petitioner's low back prior to the date of the alleged accident. Petitioner was not taking any prescribed medication for his low back or any over the counter medication for his low back on the date of accident.

On June 13, 2016, Petitioner was dispatched by Respondent to pick up a road paver from a Ritchie Brother's location outside of Chicago. He loaded the paver on his trailer and began to tie the load down with chains. Petitioner testified the chains were approximately thirty to thirty-five feet long and weighed between forty-five and fifty pounds. Petitioner started to tighten down the paver by taking the chains up and over the equipment. Petitioner testified he bent over to tighten the load with a ratchet binder and noticed some of the chain was hanging down in a position that might be too close to the hydraulic lines, so he started wrapping up the chain. In attempting to do so, he bent over and heard and felt a "pop" in his back.

Petitioner testified that he attempted to get to a standing position and, in doing so, "my legs went out from underneath me and I fell down on the trailer, off the trailer and onto the ground. Then I crawled myself back up to the cab, got myself into the truck and just – I felt like I was going to pass out. The pain was intense." Petitioner estimated the distance between the bed of the trailer and the ground was thirty-three inches. He may have been 7 to 8 feet off the ground when he was on the paver.

Petitioner testified that shortly thereafter, he composed himself and called Cindy Rush, the dispatcher for the Respondent, to whom he was supposed to report any problems to. Petitioner testified

that he told her what happened. Petitioner testified Rush then asked him if he needed an ambulance. Petitioner told her "no I just need to sit here. I need to get myself together." Petitioner also recalled telling Rush, "i mentioned that this has happened – I felt like this had happened before. About seven or eight years ago, I pulled a muscle in my back and it felt like the same thing". Petitioner testified that during this call he had "no idea how hurt I really was". Petitioner testified that the prior incident that he told Rush about was the camping incident at Rend Lake in 2006.

Cindy Rush's affidavit was submitted by agreement of the Parties. (RX D) She was the dispatcher for Respondent. On June 13, 2016, she received a call from Petitioner, who told her he had injured his back. Petitioner told her that he felt a pop in his back while he was chaining the paver/grader. Petitioner did not tell her he fell from the trailer. Rush offered Petitioner an ambulance, which he refused. After speaking with Petitioner, Rush notified her office manager, Todd Haberstroh, of the conversation. Petitioner did not tell her he was assisted with unloading the paver. (RX D)

Todd Haberstroh's affidavit was also submitted by agreement of the Parties. (RX C) Haberstroh was the Office Manager for Respondent at the time of Petitioner's accident. Rush had talked to him about her call with Petitioner on June 13, 2016. Haberstroh spoke to Petitioner on June 13, 2016. Haberstroh averred that Petitioner "advised me that he bent over to pick up either a chain or a binder from the ground and felt something pop in his back." Petitioner did not tell him that he fell from the trailer. Petitioner did not tell him of needing assistance to unload the paver. Haberstroh spoke with Petitioner on June 15, 2016 and asked Petitioner to fill out an "Employee's Report of Injury Form". Haberstroh received the completed form on June 20, 2016. The form was admitted into evidence as Respondent's Exhibit A. (RX C)

Petitioner next attempted to get in his truck to lay down. He was unable to do so. He sat in the truck and called the Respondent a second time requesting that the paver be taken off his trailer. During this time, Petitioner testified the yard manager for Richie Brothers approached the truck and said, "I know you're hurt. I can see that. He said: We will get the equipment off of your trailer". Petitioner testified the paver was removed from the trailer by employees of Ritchie Brothers, including the chains. Petitioner then again talked to Rush, telling her he wanted to drive home.

Petitioner began his drive home. When asked why he would attempt the same in so much alleged pain, the Petitioner testified, "I was scared. To be honest, sir, I was crying. I was upset. I didn't have anybody up here, and I just wanted to get home." Petitioner testified he stopped two or three times on his way back to Red Bud, Illinois. He testified that upon arrival in Waterloo, Illinois, a friend of his named "Angie" met him and took him to the Red Bud Regional Hospital Emergency room.

The medical records regarding the Red Bud emergency visit were admitted into evidence as Petitioner's Exhibit 2. The records show that Petitioner arrived at 9:24 p.m. The history given by Petitioner was: "Patient states: was lifting a chain this am and felt a pop in his lower back in Chicago then got in semi truck and drove home. Mechanism of injury: Lifting. Accompanied by Other (friend)." Petitioner presented with "9/10" pain. (Id.) The records further indicate, "Patient is pt agitated that he will not have a cortisone injection states this is what he had 7 yrs ago and it worked explained that this is usually given by pain clinic. Dr. Shaffer also explained that cortisone injections are administered by a pain clinic." (PX 2)

Petitioner was directly asked about this portion of the records at trial. He testified, he was in fact agitated and the prior incident and injection were again references to the 2006 camping incident and

subsequent treatment at Crossroads Community Hospital's emergency room. The records also reflect, "The patient has experienced a previous episode approximately six years ago. The patient is a 44 year old male with PMH herniated disk several years ago who was lifting a heavy chain earlier today complained of sharp low back pain when he lifted it radiating to left buttock and groin. He heard a loud pop and has not been able to stand up straight since...." Petitioner was again directly asked about this excerpt from the record. He testified he was again referencing the camping incident and subsequent treatment in 2006. Petitioner was given an injection, underwent a CT Scan and was discharged to home with instructions to follow up with Dr. Kirk and to "not return to full duty at work until pain free." The records inform the patient that he likely has a herniated disc. The CT of the lumbar spine revealed suggested disk bulges at L4-5 and L5-S1 with mild to moderate foraminal narrowing. (PX 2)

The Arbitrator notes that there was no evidence of a prior diagnosis of a herniated disc submitted by the Parties.

Petitioner followed up with Dr. Kirk three days later, on June 16, 2016. He had never met or been treated by Dr. Kirk previously. Chart notes indicate seen as a follow up visit for a back injury. Dr. Kirk's history of injury states: "seen for FU ER visit for acute onset of low back pain, which occurred Monday. He was lightly lifting a chain and felt a pop in his left lower back. This led to exquisite pain along the left lower back with radiation along the posterior buttocks. No loss of power or strength, no numbness or tingling." Dr. Kirk's physical exam revealed an antalgic gait and marked tenderness along the left lower lumbar region, a soft tissue mass noted (hematoma v. lipoma), positive SLR bilaterally, normal reflexes. Dr. Kirk diagnosed Petitioner with a lumbar strain and acute sciatica, referred Petitioner for physical therapy and prescribed hydrocodone and prednisone. Dr. Kirk continued to keep Petitioner off work. (PX 3)

Petitioner presented to ATI Physical therapy on June 20, 2016. The therapy notes indicate he presented with left sided low back pain limiting lifting, walking or performing his job. His functional limitations were listed as "ascending stairs, bed mobility, bending, emptying dishwasher, making bed, carrying, dressing, donning/doffing shoes/socks, driving, lifting from floor, overhead tasks, pulling/pushing tasks, sleeping more than 6 hours, standing more than 30 minutes." The notes also indicate, "significant guarding with gait and stance due to pain. Stance demo(demonstrates) spinal extension and shoulder extension at rest to prevent lumbar flexion." (PX 5) Petitioner only went to two physical therapy appointments at ATI. Petitioner was directly asked about this at trial. Petitioner testified, "Because the pain was too intense, and it was not helping."

Petitioner returned to see Dr. Kirk on June 24, 2016. The note indicates, "follow up. Lower back left side. PT hurting more. Pain medication helps only if he takes 2 tablets at a time. Flexeril knocks pt out." Petitioner was prescribed cyclobenzaprine, hydrocodone, percocet and lisinopril. Dr. Kirk further opined, "seen in FU recent work related accident where he was lifting a chain and developed sudden onset of low back pain. He was seen at RBRH where his CT scan of the lumbar spine showed no acute fracture, it did suggest disc herniation at L4-5 and L5-S1, though was a limited exam....he now has radicular symptoms including radiation along the L5 dermatome. He was given a prednisone taper, muscle relaxants and hydrocodone. The prednisone wasn't helpful and the relaxants too sedating. His symptoms suggest that he may well have an acute herniated disc. I feel he needs to proceed with MRI ASAP, which will direct his next step of tx: i.e. steroid shots, hopefully not surgery. He is struggling with his attempts to contact his work comp carrier, hopefully they will follow up soon." Dr. Kirk's assessment was, "Lumbosacral radiculitis – pt with recent work injury to his low back. His CT at RBRH ER on

6/13/2016 showed disc bulges poorly defined, he is failing PT and needs an MRI to further assess his disc, this is now a work comp injury." (PX 3)

On July 1, 2016, Petitioner underwent an MRI of his lumbar spine at Gateway Regional Medical Center. The radiologist reported that he saw a "mild circumferential broad disc bulge" at L4-5 and a "mild circumferential broad disc bulge and endplate hypertrophy, most prominent in the left foraminal and lateral regions. There is bilateral facet hypertrophy. There is mild right and moderate left neural foraminal stenosis." (RX E, PX 3) Thereafter, Dr. Kirk referred Petitioner for a neurosurgery consult. (PX 3)

On July 8, 2016, Petitioner started treating with Associated Physicians Group. (PX 4) The notes reflect the following history, "Patient complains of low back pain. Injury. The location is primarily in the lower left lumbar spine. The pain radiates to the lower extremities on the left. He characterizes it as constant, moderate in intensity, aching and numb. He states that the current episode of pain started four weeks ago. The event which precipitated this pain was at work and his knees buckled and he fell off a trailer. He was able to get into the cab of his truck, but from there was in too much pain and had to call the company to unload the trailer so that he could drive back home from the Chicago area. Once he got back to Waterloo he had a friend take him to the emergency department for evaluation due to the pain progressively getting worse. .." Petitioner was diagnosed with lumbar radiculopathy, low back pain, cervical radiculopathy and cervicalgia. He was again kept off work. Petitioner continued to treat with Associated Physicians Group. On August 16, 2016, Petitioner received a left L4-5 and L5-S1 transforaminal set of injections under fluoroscopic guidance. (PX 4) Petitioner testified that the totality of his care did not relieve his symptoms.

Dr. Kirk then referred Petitioner to Dr. Matthew Gornet, an orthopedic surgeon.

Petitioner began seeing Dr. Gornet on September 19, 2016. He presented with "low back pain to the left side with intermittent shooting pain down his left leg to his foot with numbness and tingling. He also has some right leg symptoms, but not as severe as the left." With regards to the history and mechanism of his injury, Dr. Gornet's note indicates: "He states his current problems began on 6/13/16. He was working for Hiltz Logistics. He transports oversized freight. He went to Chicago to pick up a load and he was securing the load with ratchets and chains and apparently after ratcheting, he bent over to pick up a chain and felt a pop in his back. The pain was severe and he could not moving [sic]. He basically fell off the trailer and then crawled back to his truck, where he contacted them. They took the load off of his truck. He was able to get home and then went to the emergency room." (PX 6)

With regards to any previous history of back problems, Dr. Gornet charted: "The only history of low back pain he recalls was approximately five to ten years. He had a brief severe episode of pain, which lasted for one day. He states he did not miss any significant work time. He did not have imaging studies. Other than that, he does not recall any previous problems of significance. Dr. Gornet reviewed the MRI film of June 30, 2016 and the CT scan of June 13, 2016." (PX 6)

Dr. Gornet opined, "I have discussed with the patient that the pop he felt and heard in his back was giving away of the annulus. I believe that he has injured his disc at L5-S1 and potentially at L4-5 as well as aggravating his underlying condition of facet arthropathy at L5-S1. Assuming his history is factually correct and he does not have any history of significant back problems in the past, then there is simply no other plausible explanation than to associate his current symptoms with his accident of 6/13/16." Dr. Gornet recommended a new "high quality" MRI and requested the notes from Associated Physicians

Group. Dr. Gornet prescribed Meloxicam and Cyclobenzaprine. In addition, Dr. Gornet continued Petitioner's off work status and asked that he wean himself from all narcotics. (PX 6)

Petitioner continued to treat with Dr. Gornet. He presented back on September 21, 2016 after the MRI was taken at MRI Partners the same day. (PX 6 and PX 7) Dr. Gornet opined that the MRI clearly revealed annular tears at both L4-5 and L5-S1. Dr. Gornet charted: "I have discussed with him that I believe he suffered a new disc injury at L4-5 and potentially at L5-S1 as well as aggravation of his pre-existing facet arthropathy at L5-S1. Dr. Gornet recommended epidural steroid injections at L4-5 and L5-S1 in addition to facet rhizotomies on the left at L4-5 and L5-S1 and referred Petitioner to Dr. Helen Blake. Dr. Gornet again kept Petitioner off work. (PX 6)

Petitioner underwent these injections byDr. Helen Blake and returned to see Dr. Gornet on December 5, 2016. (PX 8 and PX 6) Dr. Gornet again kept Petitioner off work. (PX 6)

Petitioner testified that none of these treatments have substantially alleviated his symptoms.

Petitioner was scheduled for a §12 exam with Dr. Frank Petkovich on February 2, 2017. (RX B) With regards to the history and mechanism of injury, Dr. Petkovich indicates, "He told me he went to pick up a piece of heavy equipment which he called a paver for road construction. He stated he was picking this up from an auction facility. Mr. Carlile told me he loaded the paver onto the bed of his truck trailer with the appropriate chains and this occurred on June 13, 2016, he felt a sudden pain and pop in his lower back. He told me this was about 12 noon. He futher told me he did notify supervisors at work at that time and that some other people around the auction facility helped him unload the paver off the trailer. He then drove his tractor trailer back to Southern Illinois to his home in Waterloo, Illinois....He also told me that as the above incident occurred on June 13, 2016, he actually fell off of the paver and onto the trailer and then onto the ground after he felt the sudden pain in his low back." (RX B)

Dr. Petkovich reviewed the treatment records. Under "Past medical history and review of systems" Dr. Petkovich opined, "Otherwise unremarkable and non-contributory. Mr. Carlile told me that he did have an episode of lower back pain in 2006 while he was on a camping trip in Southern Illinois. He told me he went to the emergency room at Crossroads Community Hospital in Mt. Vernon, Illinois at that time and received an injection for pain. Mr. Carlile told me the pain went away and he never had any significant lower back pain again until the above incident he described as occurring while at work on June 13, 2016." (RX B)

Upon physical examination, Dr. Petkovich opined he observed a normal heel to toe gait and normal lumbar clinical appearance. Dr. Petkovich opined Petitioner did sustain an accident arising out of employment and that such accident resulted in a "muscular lumbar strain". He further opined, "That muscular lumbar strain should have resolved within approximately 6 weeks from the time of that incident on June 13, 2016. The degenerative lumbar disc conditions at L4-5 and L5-S1 levels are obviously chronic and were present prior to the above incident he described as occurring while at work on June 13, 2016. I do not believe the incident he described as occurring while at work on June 13, 2016 caused any aggravation or acceleration of those degenerative disc conditions at the L4-5 and L5-S1 levels that were present prior to the incident on June 13, 2016. I believe all of Mr. Carlile's present subjective complaints of lower back pain are because of the chronic degenerative lumbar disc conditions at the L4-5 and L5-S1 levels that were present prior to the above incident on June 13, 2016." (RX B)

With regards to the medical treatment received by Carlile, Dr. Petkovich opined, "I believe his initial evaluation in the emergency department at Red Bud Hospital on June 13, 2016 and the CT lumbar spine were reasonable and appropriate. I also believe his follow up with Dr. Michael Kirk was reasonable and appropriate. I believe the MRI lumbar spine taken on June 30, 2016 was also reasonable and appropriate as a result of the above incident he described as occurring while at work on June 13, 2016. I believe referral to physical therapy was appropriate. I do not believe any further diagnostic evaluation or treatment beyond approximately 6 weeks of physical therapy following the above incident on June 13, 2016 was reasonable and appropriate as a result of that incident on June 30, 2016. I do not believe it was necessary for Mr. Carlile to have been referred to Associated Physicians Group as a result of that incident that he described as occurring while at work on June 13, 2016. I do not believe any of the injections performed at that facility were necessary as a result of the incident on June 13, 2016. Mr. Carlile should have continued with the physical therapy as originally ordered…I do not believe it was necessary for Mr. Carlile to be seen by Dr. Gornet. Ultimately, Dr. Petkovich opined Petitioner should have returned to work at full duty six weeks after the accident. (RX B)

Petitioner testified that he wished to undergo the MRI spectroscopy and discogram as ordered by Dr. Gornet. He testified the reason he wished to undergo the procedures was "because I want to get fixed. I just want to go back to work."

Petitioner was questioned under direct examination about Dr. Gornet's recommendation that he wean off all narcotics. He responded he done so to "a great deal" and it had been very difficult for him. On cross-examination, Petitioner further admitted not being able to fully wean off narcotics, testifying he had gotten Percocet and Vicodin from someone not his physician. Petitioner further admitted to being unable to quit smoking as recommended by his doctors.

Petitioner confirmed he had been excused off work by all of his doctors since the inception of his treatment on the day of the accident.

As evidenced by both the affidavit of Todd Haberstroh and Petitioner's testimony, after receipt of the Dr. Petkovich IME, Petitioner was offered a full duty return to work by the Respondent. Petitioner did not return to work. When asked why he did not return to work as instructed, Petitioner testified, "Because I was hurt." Petitioner testified further, that based on his experience as a truck driver, it would have been dangerous for him to return to work at full duty. Respondent stopped benefits based upon Dr. Petkovich's report. Petitioner testified that, at the time his benefits were cut off, he had been attending all of his scheduled medical appointments and cooperating completely with Respondent's carrier.

Petitioner testified with regards to his current state of ill-being, "Sir, my life is pretty much miserable, to be honest with you. I loved working. I want to get back to it eventually one day. I wake up in pain. I go to bed in pain. I don't get very much exercise, because it hurts. The loss of – I've pretty much lost everything sir. I'm getting ready to lose much more. I know they are physical things. I can get them back sooner or later one day. But the situation of not having any income in and you're depending on your family to help you has been traumatic. I don't ask anyone for anything. I've earned everything I've got. I've been a hard worker my whole life."

Prior to his current medical treatment after the June 13, 2016 accident, it is undisputed that Petitioner never had an MRI of his lumber spine, never had been prescribed medications for his lumbar spine and had never been prescribed physical therapy for his lumbar spine.

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). 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 (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 Arbitrator finds Petitioner's testimony to be credible. The Arbitrator observed Petitioner's demeanor under a thorough cross-examination. The medical records, the accident report and the affidavits of Rush and Haberstroh corroborate Petitioner's testimony. The issue of the fall off of the trailer and the minor inconsistencies in Petitioner's testimony regarding the facts of the accident and the events after the accident do not persuade the Arbitrator that Petitioner's testimony was false.

C. ACCIDENT

Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on June 13, 2016 while securing the paver to the trailer. The Arbitrator bases this finding on the testimony of Petitioner, the medical records, the accident report and the affidavits of Rush and Haberstroh.

E. NOTICE

Petitioner provided proper notice, in accordance with Section 6 of the Act. This finding is based on Petitioner's testimony, the accident report and the affidavits of Rush and Haberstroh.

F. CAUSAL CONNECTION

Petitioner's current condition of ill-being (to wit: disc injury at L4-5 and potentially at L5-S1, as well as aggravation of preexisting arthropathy at L5-S1, as described by Dr. Gornet) is causally related to his accident of June 13, 2016. This finding is based on the testimony of Petitioner, the opinion of Dr. Gornet and the medical records adduced. Petitioner was able to perform his physical job prior to the accident. There was no evidence of any prior back problems, other than the ER visit at Crossroads in 2006 (which was honestly disclosed by Petitioner to Respondent, his medical providers and the Arbitrator.

While Dr. Petkovich opined that Petitioner suffered an accident which arose out of and in the course of his employment, for which he should have received treatment for six weeks following, he did not agree with any treatment or restrictions thereafter. Based upon the totality of the Record, including Petitioner's credible testimony, the Arbitrator finds the opinions of Dr. Gornet more persuasive than those of Dr. Petkovich on the issue of causation.

J. INCURRED MEDICAL EXPENSES

The medical services provided to Petitioner were reasonable and necessary to cure or relieve the effects of the injury. This finding is based upon the Arbitrator's finding above regarding causation, Petitioner's testimony and the treating medical records.

Dr. Petkovich's opinions regarding treatment are not persuasive in this case.

Accordingly, the following medical bills are awarded:

MFG Spine LLC (Dr. Gornet): (PX 9)	**$2,133.60**
MRI Partners of Chesterfield: (PX 10)	**2,300.00**
Pain and Rehabilitation Specialists, LLC: (PX 11)	**7,884.00**
Orthopedic Associates of Chesterfield: (PX 12)	**17,564.90**
Red Bud Regional Clinic Co.: (PX 13)	**162.15**
Red Bud Regional Hospital: (PX 14)	**7,082.05**
ATI Physical Therapy: (PX 15)	**589.71**
Associated Physicians Group: (PX 16)	**1,755.00**

This award is made pursuant to Sections 8(a) and 8.2 of the Act. Respondent is entitled to a credit for all bills that it paid.

K. PROSPECTIVE MEDICAL CARE

The Parties agreed that the claim for prospective medical care was limited to the CT discogram and MRI spectroscopy procedures recommended by Dr. Gornet.

The Arbitrator finds that Petitioner is entitled to this prospective medical care, based upon the Arbitrator's finding above regarding causation and Dr. Gornet's records. Accordingly, Respondent shall authorize and pay for the MRI spectroscopy and the CT discogram described by Dr. Gornet in his February 13, 2017 chart note, along with all related services.

Petitioner is urged to cease the use of narcotic medications, to lose weight and to stop smoking, as recommended by Dr. Gornet.

L. TTD

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from the day following his accident to the day proofs were closed (6/14/2016 to 6/12/2017). Accordingly, Respondent shall pay Petitioner TTD benefits of $854.80/week for 51-6/7 weeks, as provided in §8(b) of the Act.

N. IS RESPONDENT DUE ANY CREDIT?

Respondent is due a credit for all compensation benefits it has paid against the award for TTD and for all awarded medical bills that it has paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANKAKEE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRANDON PLATA,

Petitioner,

vs.

NO: 15 WC 24074
15 WC 24075

DOLLAR TREE DISTRIBUTION,

Respondent.

18IWCC0158

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, nature and extent of 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 notes that the medical records and Functional Capacity Evaluation performed on May 19, 2016 establish that Petitioner has restrictions that limit his ability to bend, lift and twist. These restrictions permit work only at a light physical demand level and shorten the length of his work day.

The Commission hereby modifies the award of permanent partial disability in case number 15 WC 24075 from 15% loss of use of the person as a whole to 17 1/2 % pursuant to section 8(d)(2) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $545.69 per week for a period of 57 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 $491.12 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 loss of 17.5% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable, necessary and causally related medical expenses incurred through September 22, 2016 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 19 2018
o-1/25/18
SM/msb
44

Stephen Mathis

David L. Gore

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PLATA, BRANDON A
Employee/Petitioner

Case# **15WC024074**

15WC024075

DOLLAR TREE DISTRIBUTION
Employer/Respondent

18IWCC0158

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:

1987 RUBIN LAW GROUP LTD
CATHERINE K DOAN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

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

18IWCC0158

STATE OF ILLINOIS)
)SS.
COUNTY OF KANKAKEE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Brandon A. Plata
Employee/Petitioner

v.

Dollar Tree Distribution
Employer/Respondent

Case # **15 WC 24074**

Consolidated cases: **15 WC 24075**

An *Application for Adjustment 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 **Kankakee**, on **May 18, 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 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 5/22/2015 and July 13, 2015, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

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

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

Petitioner's current condition of ill-being *is* causally related solely to the accident of July 13, 2015 through September 22, 2016. SEE DECISION

In the year preceding the injury, Petitioner earned **$42,563.56** ; the average weekly wage was **$818.53**.

On the date of accident, Petitioner was **27** years of age, ***married*** with **1** 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 **$34,456.27** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$34,456.27**.

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

ORDER

Petitioner is not entitled to benefits for the accident of 5/22/15 in case 15 WC 24074. SEE DECISION
The following orders pertain to the accident on 7/13/15 in case 15 WC 24075. SEE DECISION

Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred through 9/22/16 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner temporary total disability of $545.69 per week for a period of 57-3/7 weeks commencing 8/17/15 through 9/21/16. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner $491.12 per week for a period of 75 weeks as Petitioner sustained 15% loss of use of the person as a whole pursuant to 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.

Carolyn M. O'Neill

Signature of Arbitrator

6/24/17

date

JUN 27 2017

FINDINGS OF FACT

The Arbitrator notes that Petitioner presented two consolidated matters for trial. In case 15 WC 24074 Petitioner alleges an accident date of 5/22/15 and in case 15 WC 24075 Petitioner alleges an accident date of 7/13/15. ARB EX 1 and ARB EX 2.

Petitioner attended Lockport High School from approximately 2004 through 2007. He did not graduate from high school. Petitioner testified that he completed a GED. He just completed his GED in April 2017. Petitioner has certifications in spotting and food services. He also has a class C driver's license.

At trial on May 18, 2017. Petitioner credibly testified that he was employed by Respondent on May 22, 2015 as a level 200, or L2, department manager. Prior to May 22, 2015, he had been employed by Respondent for approximately four (4) years. Petitioner testified that he was employed as an L2 department manager for Respondent on July 13, 2015 as well. Petitioner described his job duties as a department manager for Respondent. Petitioner testified that he oversaw the daily functions of the department and the associates. He worked in the shipping department. Petitioner made sure that the correct product was in the correct door and assisted in any task that was necessary for the running of the department. Petitioner testified that he performed lifting and carrying as part of his job duties. The heaviest object that he lifted was a safe, which weighed approximately 120 pounds. On a daily basis he lifted bottles of bleach which weighed between 60 and 70 pounds. Petitioner climbed ladders. Petitioner also reached to stack products and grab objects off the convey belt. Petitioner pushed and pulled pallets. The heaviest object that he pushed and pulled was a pallet weighing approximately 300 pounds. As part of his job duties, Petitioner bent and squatted to pick up boxes. He also stood and walked all day. Petitioner testified that he worked between ten (10) and twelve (12) hours per day. He had two (2) breaks and lunch.

Petitioner testified that he performed all of the job duties prior to May 22, 2015 without any difficulty. Petitioner testified that prior to May 22, 2015 he had not received any medical treatment for his back. Further, he had not sustained any accidents of injuries involving his back prior to May 22, 2015. The Arbitrator notes that Respondent does not dispute accident or notice in either case. ARB EX 1 and ARB EX 2.

The 27 year old Petitioner testified that he was performing his job duties for Respondent on May 22, 2015. On that date he was working in the shipping department at door 54. Petitioner was working on a conveyer belt. A pin popped out causing the boxes to keep coming at Petitioner. Petitioner was hit in the chest by a box. The box pushed Petitioner backwards over the conveyer. Petitioner hyper extended his back. Petitioner experienced pain in his back following the work-related accident of May 22, 2015.

Petitioner testified that he did not seek medical treatment following the work-related accident of May 22, 2015. Petitioner continued to work for Respondent as an L2 department manager. He testified that his back hurt while he performed his job duties for Respondent. Petitioner did not sustain any accidents or injuries between May 22, 2015 and July 13, 2015.

Petitioner testified that he was again performing his job duties for Respondent on July 13, 2015. Petitioner was working at door 39 in the shipping department. He picked up a box of bleach, which weighed approximately 70 pounds. As Petitioner was lifting the bleach, he felt a pop in his back. Petitioner immediately experienced pain in his lower back. Petitioner testified that he had difficulty walking. Petitioner testified that following the July 13, 2015 accident, the pain in his back was worse than following the May 22, 2015 accident.

Following the work-related accident of July 13, 2015 Petitioner sought medical treatment on July 14, 2015. Petitioner was initially examined at Physicians Immediate Care on July 14, 2014. (PX 1). Petitioner provided a history of a May 22, 2015 injury at work when boxes on a roller system caused him to hyperextend his back over a wall of boxes. Petitioner reported that his back slowly improved over time and was significantly better 2 weeks before his visit. He next reported that on July 13, 2015 when he was lifting boxes of bleach weighing 50 to sixty 60 pounds and felt a pop in his back with pain in his back radiating to the right shin. (PX 1). Following exam with abnormal results, Petitioner was diagnosed with lumbar sprain and strain and was released to return to work with restrictions. (PX 1). He had another follow up appointment at Physicians Immediate Care on July 17, 2015 where he was again diagnosed with a lumbar sprain strain and given work restrictions. (PX 1).

Petitioner was examined by his primary care physician, Dr. Connelly, on July 20, 2015. (PX 2). Dr. Connelly recommended Tramdol, physical therapy and an MRI study of the lumbar spine along with light duty restrictions. (PX 2). She also recommended that Petitioner be examined by an orthopedic surgeon. (PX 2). Petitioner underwent the recommended MRI study on July 27, 2015 at Channahon Healthcare Center. (PX 3). The MRI study revealed bilateral spondylolysis at L5 with grade 2 anterolisthesis of the L5-S1 and moderate bilateral foraminal stenosis. (PX 3). Dr. Connelly continued the work restrictions on July 29, 2015. PX 2

Petitioner was examined by Dr. Lorenz at Hinsdale Orthopedic on August 6, 2015. (PX 4). Dr. Lorenz documented the May 22, 2015 and July 13, 2015 accidents. (PX 4). Dr. Lorenz set forth an assessment of thoracic lumbosacral neuritis or radiculitis unspecified and spondylolisthesis. (PX 4). Dr. Lorenz recommended Tramadol and injections. (PX 4). He noted that Petitioner was unable to return to work. (PX 4).

Pursuant to the recommendations of Dr. Lorenz, Petitioner was examined by Dr. Koehn for pain management. (PX 5). Dr. Koehn documented that Petitioner sustained a work-related accident. (PX 5). He set forth an impression of stenosis spinal, lumbar region without neurogenic claudication, lumbar disc displacement without myelopathy, degenerative lumbar lumbosacral disc without myelopathy, lumbosacral spondylosis, lumbago and UNS thoracic lumbar neuritis/radiculitis. (PX 5). He recommended Norco and a transforaminal ESI. (PX 5). Petitioner underwent the ESI on August 20, 2015. (PX 4). The ESI was performed by Dr. Koehn at the L5 and S1 level. (PX 4).

Petitioner had a follow up examination with Dr. Lorenz on August 27, 2015. (PX 4). Dr. Lorenz noted that the ESI did not provide relief to Petitioner and that Petitioner continued to have positive straight leg raise on the right with continued radicular complaints in the right lower extremity. (PX 4). Dr. Lorenz recommended additional physical therapy and that Petitioner remain off work. (PX 4). He stated that if Petitioner failed conservative care, then he would be a candidate for spondylolysis repair and decompression. (PX 4). Dr. Lorenz set forth that the work-related accident aggravated Petitioner's pre-existing condition of spondylolisthesis causing his current condition of ill-being and the radiculopathy. (PX 4).

Petitioner was again examined by Dr. Lorenz on October 12, 2015. (PX 4). Petitioner complained of worsened back pain with physical therapy and was considering fusion surgery. Dr. Lorenz referred Petitioner for dietary consultation and a weight loss program advising that Petitioner lose 30 pounds. (PX 4). He stated that if Petitioner lost weight then he would be a candidate for a fusion at L4-S1. (PX 4). Petitioner continued to have follow up appointments with Dr. Lorenz. (PX 4). Petitioner testified that the weight loss program was not authorized by Respondent. Eventually Dr. Lorenz noted that by March 2016 Petitioner had seen a dietician twice and lost 2 pounds. PX 4.

On May 16, 2016, Dr. Lorenz noted that Petitioner's weight loss efforts continued and that Petitioner continued his complaints of right sided lumbar back pain with radiation numbness and tingling extending down the right leg. He noted that since Petitioner had not lost the required weight his choices were to have the surgery or live with the pain. He chose to live with the pain. Dr. Lorenz ordered an FCE and a return to work under the FCE parameters. Petitioner opted for the FCE and against surgery. Dr. Lorenz ordered the FCE and also referred Petitioner to pain management. (PX 4). He also kept Petitioner off work. (PX 4).

Petitioner underwent the FCE at ATI Physical Therapy on May 19, 2016. (PX 6). The FCE was valid and set forth that Petitioner could work at a light physical demand level. (PX 6). The FCE set forth that Petitioner could lift above the shoulder at 17 pounds occasionally, desk to chair of 25.8 pounds occasionally, chair to floor of 10.4 pounds occasionally and carry 22 pounds on the left occasionally and 17 pounds on the right occasionally. (PX 6). Petitioner could work for 3 hours per day, stand for 1 hour 10 minutes and walk for one to two hours. (PX 6). He was also allowed to sit for 3 hours in 30 minute durations. Petitioner also had physical limitations with balance, bending/stooping, climbing stairs, crawling, crouching, right and left foot repetitive movement, kneeling and squatting. (PX 6). Petitioner's physical capabilities fell below his job requirements which the FCE reflected was at the medium level. (PX 6).

Petitioner was examined by Dr. Lorenz on June 6, 2016. (PX 4). Dr. Lorenz noted that Petitioner had limited range of motion secondary to pain but was ambulating without difficulty. (PX 4). He set forth that Petitioner could return to work at the level of the FCE which Dr. Lorenz noted was permanent light duty work only. (PX 4). He noted a maximum lifting of fifteen pounds. (PX 4). Dr. Lorenz again referred Petitioner to pain management. (PX 4).

On August 1, 2016, Dr. Connelly referred Petitioner to Pain Centers of Chicago for pain management. (PX 2). Petitioner was examined by Dr. Estilo on November 3, 2016. (PX 8). Dr. Estilo noted that Petitioner had back pain as a result of a work-related accident. (PX 8). She set forth a diagnosis of chronic lumbar radiculopathy, lumbar foraminal stenosis, grade 2 and L5-S1 anterolisthesis. (PX 8). Dr. Estilo recommended that Petitioner avoid bending through the waist and lose weight. (PX 8). She recommended an ESI. (PX 8). On November 17, 2016 Petitioner canceled the ESI advising that he no longer wanted the procedure. On a follow up visit with Dr. Estilo and December 8, 2016, the ESI was again scheduled. (PX 8).

On January 24, 2017, Petitioner was examined by Dr. Schmidt for pain management. (PX 9). Petitioner was referred to Dr. Schmidt by Dr. Estilo because Dr. Estilo did not accept Petitioner's new insurance. Dr. Schmidt documented both Petitioners' work related accidents. (PX 9). He stated that Petitioner was a surgical candidate, but that "the neurosurgeons" recommended medication management due to his age. (PX 9). On physical examination, Petitioner had paralumbar tenderness, buttocks tenderness and positive straight leg raises. (PX 9). Dr. Schmidt set forth a diagnosis of degeneration of the lumbar/lumbosacral intervertebral disc, lumbar radiculopathy, spinal stenosis of the lumbar region without neurogenic claudication and lumbosacral spondylosis without myelopathy. (PX 9). Dr. Schmidt recommended Norco, Topamax, Baclofen, weight loss and restrictions pursuant to the FCE. (PX 9).

Petitioner was again examined by Dr. Schmidt on February 14, 2017. (PX 9). On physical examination, Petitioner had positive TTP across the lower back and paralumbar region. (PX 9). Dr. Schmidt refilled Petitioner's medication, encouraged continued weight loss and considered an increase in Topamax. (PX 9). Petitioner continued to be prescribed medication through Dr. Schmidt. Dr. Schmidt noted that Petitioner had started working for a new employer within the FCE parameters.

- At the request of Respondent, Petitioner was examined by Dr. Frank Phillips on two occasions. (PX 7). Petitioner was first examined by Dr. Phillips on September 8, 2015. (PX 7). Dr. Phillips reviewed the MRI study from July 27, 2015. (PX 7). The MRI revealed L5-S1 grade 1 to 2 spondylolisthesis and disc desiccation at L4-L5 and L5-S1 and L5-S1 lysis and spondylolisthesis and severe foraminal stenosis bilaterally. (PX 7). Dr. Phillips stated that both the injuries were responsible for aggravating symptoms related to the underlying spondylolisthesis. (PX 7). He recommended additional conservative treatment, including therapy. (PX 7). He stated that Petitioner could be a candidate for a lumbar fusion if Petitioner's condition did not improve. (PX 7).

- Dr. Phillips set forth that Petitioner had underlying L5-S1 unstable spondylolisthesis with an aggravation of symptoms related to both the May and July 2015 work injuries. (PX 7). He stated that the work injuries were contributing factors to Petitioner's current condition of ill-being and were based on the objective imaging studies. (PX 7). Dr. Phillips based his opinion that the work injury aggravated a pre-existing condition on the objective findings of the MRI, the description of the accident and the fact that the underlying condition increased Petitioner's risk of a work injury. (PX 7). Dr. Phillips found that the medical treatment provided to Petitioner was reasonable, necessary and related to the work-related accident and recommended more physical therapy and injections. (PX 7). He stated that Petitioner could be a surgical candidate. (PX 7). Dr. Phillips released Petitioner to return to work in a sedentary capacity and to avoid lifting more than fifteen pounds and repetitive bending and twisting. (PX 7).

Dr. Phillips again examined Petitioner on May 12, 2016. (PX 7). On physical examination, Dr. Phillips found that Petitioner had an antalgic gait with difficulty heel walking, limited range of motion, diminished sensation in the right shin and positive straight leg raise. (PX 7). Dr. Phillips set forth that Petitioner had reached MMI with regard to his underlying lumbar condition. (PX 7). He noted that if Petitioner declined surgery then he was at MMI and Dr. Phillips would recommend an FCE to assess validity and Petitioner's functional levels. (PX 7). Dr. Phillips stated that if Petitioner proceeded with surgery, the surgery would be reasonable and related to the injury in question. (PX 7).

Dr. Phillips set forth a diagnosis of L5-S1 spondylolisthesis supported by the objective MRI findings. (PX 7). He stated that if Petitioner chose to proceed with surgery then the surgery would be medically necessary and related to the injury. (PX 7). Dr. Phillips set forth that the treatment to date had been reasonable and necessary. (PX 7). He stated that if Petitioner declines surgery than he had reached MMI. (PX 7). If Petitioner did undergo surgery, then MMI would be based on Petitioner's response to the treatment. (PX 7). Dr. Phillips set forth that Petitioner was at MMI for conservative treatment if he did not undergo surgery or was felt not to be a surgical candidate by his treating physician. (PX 7). Dr. Phillips set forth a restriction of avoiding lifting over fifteen (15) pounds and repetitive bending and twisting. (PX 7). Dr. Phillips set forth that Petitioner's weight did not have a direct relationship to his current condition of ill-being and that the current condition of ill-being was not a direct consequence of Petitioner weight. (PX 7). He stated that Petitioner's weight affected Petitioner's decision making as to whether or not surgery was feasible and may be impairing his recovery given the reluctance of his treating physician to perform the surgery due to Petitioner's weight. (PX 7).

The medical bills from Dr. Estilo (PX 17) and Dr. Schmidt (PX 18) were admitted into evidence. Dr. Estilo's medical bill reflected total charges of $518. (PX 17). The medical bill was paid through Medicaid. (PX 17). The medical bill of Dr. Schmidt reflects total charges of $490. (PX 18). The medical bill was paid through Public Aid. (PX 18). The receipts in connection with the out of pocket payments that Petitioner made were also admitted into evidence. (PX 16). Petitioner paid a total of $433.95 for prescription medication and appointments with his treating physicians. (PX 16).

Petitioner contacted Respondent when he was released with permanent restrictions by Dr. Lorenz. Petitioner contacted Dawn Sutter. Petitioner was not provided with work within his restrictions by Respondent. Respondent did not offer Petitioner vocational rehabilitation services. Rather, Petitioner conducted a self-directed job search. He contacted employers online and dropped off applications for employment. Petitioner documented his job search on forms. Petitioner's job search was admitted into evidence. (PX 11). Petitioner participated in a job search from July 2, 2016 through November 4, 2016. (PX 11). Petitioner was paid TTD through October 20, 2016.

As a result of his job search, Petitioner obtained employment. Petitioner was offered a job with Minooka Collision. Petitioner accepted the position as a front end secretary. Petitioner began work for Minooka Collision at the front desk on November 20, 2016. Petitioner earned $10 per hour and the job was 15 hours per week. The pay stubs from Minooka Collision were admitted into evidence and corroborated Petitioner's testimony that he earned $150 per week. (PX 12). Petitioner testified that the job was within his restrictions. He testified that the job required minimal lifting, carrying, pushing/pulling or physical activity. He answered phones and performed office work and answered phones. He occasionally bent, swept the floor or emptied a light trash can which weighed approximately ten (10) pounds.

Petitioner was interviewed by Edward Pagella on September 7, 2016. (PX 10). Mr. Pagella relied on the FCE since it was valid and recommended by both Dr. Lorenz and Respondent's Section 12 physician, Dr. Phillips. (PX 10). Mr. Pagella opined that based on the restrictions, Petitioner would not be able to return to work as an L2 department manager for Respondent. (PX 10). Mr. Pagella recommended vocational rehabilitation services to assist Petitioner with devising a resume, teaching him job seeking skills and interview techniques and speak to potential employers on his behalf. (PX 10). Mr. Pagella also noted that a GED would be beneficial to Petitioner. (PX 10). Mr. Pagella opined that Petitioner had 4 main barriers to obtaining employment: Limited education and no GED; He was only able to work 3 hours per day; He had permanent medical restrictions; He needed an employer who would tolerate his tattoos and piercings. (PX 10).

The evidence deposition of Mr. Pagella was completed on February 24, 2017. (PX 15). Mr. Pagella testified that Petitioner could not return to his job for Respondent. (PX 15 at 16). Mr. Pagella's opinion was based on the valid FCE. (PX 15 at 17-18). Mr. Pagella stated that Petitioner's job duties for Respondent would constitute a heavy physical demand level. (PX 15 at 18). He based his opinion on the fact that Petitioner's job required him to lift boxes, load trucks and operative a fork lift. (PX 15 at 18). At the time of the report, Mr. Pagella recommended vocational job placement services. (PX 15 at 18-19). Mr. Pagella noted that his vocational rehabilitation plan would have been similar to the job search that Petitioner performed. (PX 15 at 19). He opined that Petitioner, on his own, was able to obtain suitable employment. (PX 15 at 19). Mr. Pagella testified that Petitioner participated in a diligent job search since he was able to obtain employment. (PX 15 at 21). Further, Petitioner applied for appreciate jobs during his job search. (PX 15 at 21).

Mr. Pagella opined that Petitioner's employment with Minooka Collision constituted suitable employment. (PX 15 at 21). He testified that the job was viable and consistent within the labor market, was at a sedentary level and allowed Petitioner to change position during the day. (PX 15 at 21). Mr. Pagella would not recommend further vocational rehabilitation services since Petitioner obtained suitable employment. (PX 15 at 22). On cross exam, Mr. Pagella testified that Petitioner had large spacers in Petitioner's ears creating big holes. PX 15, p. 35. Petitioner testified that Mr. Pagella never told him to cover up his tattoos or take out his piercings because they might be a hindrance to his employment. (T. at 40-41).

At trial, Petitioner complained of lower back pain that radiates up the right side and down his right leg. (T. at 32); An occasional limp, depending on how his back feels. (T. at 41-42); Aggravated back pain if he walks, stands or sits for too long. (*Id.*); Aggravated back pain when he lifts his 2 year old son, who weighs approximately 28 pounds. (T. at 43). "It kills [him] every day when [he] can't lift him up."; aggravated back pain when he goes beyond his permanent restrictions, which prevents him from working. (T. at 44).

Respondent submitted surveillance video of Petitioner. (RX 5-7). Surveillance was conducted on September 17-18, 2016, September 22, 2016, September 27-28, 2017 and November 19, 2016. (RX 5-7). The Arbitrator watched all of the surveillance video. On September 17, 2016, Petitioner was not observed. (RX 5). On September 18, 2016, Petitioner left the house on several occasions. (RX 5). The many occasions, Petitioner was behind a car and the Arbitrator could not observe anything. (RX 5). On one occasion, Petitioner exited his house, retrieved an object and walked back to his house. (RX 5).

On September 22, 2016, Petitioner went to a gas station. (RX 6). Petitioner then went to Target for approximately 1.5 hours with his family and a friend. (RX 6). While entering the store, Petitioner carried his toddler child. (RX 6). At the time of the hearing, Petitioner testified that his son weighed 28 pounds. The surveillance took place in September 2016, almost eight (8) months prior to the hearing. Petitioner also shifted the child from arm to arm while carrying him into the store. (RX 6). Petitioner and the group are depicted shopping in Target. Petitioner pushed the cart or walked behind it while in the store. (RX 6). Petitioner is seen vertically lifting and maneuvering several large boxes which appear to be shelving or furniture and carrying two of these boxes to the cart where he bent down to the ground and loaded the boxes onto the bottom of the cart. The boxes appeared to be heavy. (RX 6). Petitioner did squat to load the cart and maneuver the boxes in place. (RX 6). The Arbitrator did not view any pain behavior following this activity. Petitioner carried bags of items to the car, shifted items in the back of his Dodge Ram 1500 truck and then loaded the boxes into the back of the truck. On September 27, 2016, put gas in his truck. (RX 6).

On September 28, 2016, Petitioner went to McDonalds. (RX 6). Petitioner also went to the hospital with his wife and child. (RX 6). Petitioner carried his child during the day. (RX 6). Petitioner went shopping at Walmart. (RX 6). He inspected a treadmill. (RX 6). Although the video is difficult to see, it appears that Petitioner climbed the shelf to see something. RX 6 at 14:16. Petitioner is then depicted with two Walmart employees while the treadmill is loaded into the back of his truck. The two men actually lifted the treadmill into the truck but Petitioner is depicted assisting the two men to push the treadmill into the truck. (RX 6). Petitioner is then seen covering the treadmill with a tarp and climbing on the truck to do so. He is also seen jumping off the truck during this process. (RX 6). With the help of another man, Petitioner is then seen maneuvering the treadmill into his house and specifically pushing and pulling the treadmill to get it into the home. (RX 6). Petitioner did not lift the treadmill. The other man pushed the treadmill while Petitioner steadied it and assisted in moving it into the house. (RX 6). The Arbitrator notes that once the treadmill reached the house, Petitioner cannot be seen on the video. (RX 6).

On November 19, 2016, Petitioner lifted his infant child into the car. (RX 7). He put gas in his car. (RX 7). Petitioner went to Arby's. (PX 7). Petitioner carried his baby through the parking lot. (RX 7). The Arbitrator notes that the child is an infant. Petitioner loaded the truck with a car seat and empty stroller. (RX 7). Petitioner also went to Subway. (RX 7). The Arbitrator notes that at many points during the videos, Petitioner is seen carrying the infant child in a baby seat loading the seat with the baby in the seat into the car and then lifting the seat out of the car. RX 6, RX 7.

Petitioner testified regarding his current subjective complaints. Petitioner testified that he experiences pain in his lower back which radiates down his right leg. Petitioner avoids activities which cause him pain and he tries to follow his restrictions. He also testified that he tried to avoid lifting anything outside of his restrictions. Petitioner notes that some days are better than others and sometimes he is able to walk better than others. Petitioner testified that he does pick up his son, who weighs approximately 28 pounds. He acknowledged that this is outside of his restrictions, but refuses to not pick up his children if necessary. Petitioner testified that he cannot pick up his children as much as he wants and that is devastating.

Petitioner testified that he takes prescription medication for the pain, including Norco and Topamax. Petitioner also performs stretching at home. Petitioner testified that he is trying to lose weight. He was recommended a dietician; however, Respondent did not authorize payment for the dietician. On his own, he has lost approximately eighteen (18) pounds. Petitioner testified that he did not sustain any accidents or injuries involving his back since July 13, 2015.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law. The following conclusions of law apply to both consolidated cases 15 WC 24074 and 15 WC 24075.

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

The Arbitrator again notes that accident is not in dispute in either matter. The Arbitrator finds that as a result of the undisputed work-related accident of May 22, 2015 Petitioner sustained only a temporary aggravation of his pre-existing low back condition. Following the work-related accident of May 22, 2015, Petitioner experienced pain in his back. However, he continued working and did not seek any medical treatment following the work-related accident of May 22, 2015. Later medical records indicate that his back slowly improved over a few weeks after the May 22, 2015 accident. Thus, the Arbitrator finds that Petitioner's condition of ill-being in his low back was only temporarily aggravated and thereafter returned to base line condition. No benefits are awarded in connection with the May 22, 2015 accident in case 15 WC 24074.

It is undisputed that Petitioner sustained a second accident at work on July 13, 2015 which increased the symptoms in his back. Petitioner testified that the pain in his back was worse following the work-related accident of July 13, 2015. Immediately following the work-related accident of July 13, 2015, Petitioner sought medical treatment. Again, Respondent does not dispute accident on this date. The Arbitrator thus finds that Petitioner sustained a work related accident on July 13, 2015.

With regard to causal connection, it is not lost on the Arbitrator that all of the medical opinions in this case, including that of the Section 12 physician, support a finding that Petitioner's accident of July 15, 2013 caused an aggravation of his pre-existing low back condition and that his current condition of ill-being is causally related to the July 15, 2013 accident. However, Respondent's dispute regarding causal connection for Petitioner's current condition is primarily based on the surveillance video depictions of Petitioner in September and November of 2016, subsequent to the medical opinions rendered. Respondent asserts the video evidence is sufficient to rebut the medical opinions and preclude a finding of causal connection for Petitioner's current condition of ill-being. The Arbitrator further notes that the treating and examining physicians agreed with the FCE restrictions imposed in May of 2016, which placed Petitioner at the light duty level and below his Medium

level duties. Again, Respondent asserts the video depiction of Petitioner sufficiently disputes those restrictions and negates his asserted inability to return to his pre-injury work levels. Based upon a review of the credible evidence at trial, including the videos, medical evidence and Petitioner's testimony, the Arbitrator agrees.

Upon review of the videos, the Arbitrator was not given pause by certain abilities demonstrated by Petitioner, specifically those of carrying his children with or without child seats, lifting strollers, walking without hindrance or putting gas in his truck. However, the Arbitrator notes that the depiction of Petitioner lifting boxes at Target and bending to place them under his cart as well as maneuvering a treadmill on and off his truck, climbing on the truck and jumping off the truck, clearly depict Petitioner with abilities greater than those documented at the FCE and those testified to at trial. While recognizing that the video depicts only a short portion of Petitioner's daily life and that Petitioner is not seen performing these activities on a repetitive basis, the Arbitrator notes Petitioner is depicted as clearly able to perform activities outside his restrictions with agility and pain free motion. The Arbitrator further finds that the video activity casts sufficient doubt on the credibility of the May 2016 FCE restrictions and the continued necessity of those restrictions in September 2016. Accordingly, based on a preponderance of the credible evidence at trial, including consideration of the opinions set forth by the treating and examining physicians, the Arbitrator finds causal connection between the undisputed accident of July 13, 2015 and Petitioner's aggravated low back condition through September 22, 2016, the date of video surveillance depicting the abilities described above. Petitioner's condition thereafter is not causally connected.

In support of the Arbitrator's decision relating to "J," whether the medical services were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator makes the following conclusions:

Based on the Arbitrator's finding on the issue of causal connection through 9/22/16, the Arbitrator further finds that Respondent has paid all appropriate charges for all reasonable and necessary medical services, and is not responsible for payment of Dr. Estilo's charges of $518.00, Dr. Schmidt's charges of $490.00 or Petitioner's out-of-pocket prescription expenses, totaling $433.95. Petitioner started treating with Dr. Estilo on 11/3/16. (PX 8). Petitioner started treating with Dr. Schmidt on 1/24/17. (PX 9).

In support of the Arbitrator's decision relating to "L," temporary total disability benefits, the Arbitrator makes the following conclusions:

Based on the Arbitrator's findings on the issue of causal connection through 9/22/16, the Arbitrator finds that Petitioner was temporarily and totally disabled for the period of 57-3/7 weeks commencing 8/17/15 through 9/21/16. Respondent does not owe benefits thereafter, including maintenance benefits.

In support of the Arbitrator's decision, related to "L," nature and extent of the injury, the Arbitrator concludes as follows:

Based on the Arbitrator's findings on the issue of causal connection through 9/22/16, and specifically the video depiction of Petitioner's physical ability casting sufficient doubt on the necessity of the FCE restrictions, the Arbitrator further finds that Petitioner is not entitled to the requested wage differential award under Section 8(d)(1) based upon a preponderance of the credible evidence at trial.

Having found that Petitioner's sustained an aggravation of his low back condition on July 13, 2015 causally related through 9/22/16, the Arbitrator applies the following 5 factors to determine his disability under Section 8(d)(2) of the Act.

(i): Reported Level of Impairment

No impairment rating was admitted. Therefore, the Arbitrator gives no weight to this factor.

(ii): Occupation Of The Employee

Petitioner testified that his job with Respondent, required him to lift and carry product and put product into trailers. Petitioner also pushed and pulled pallets in and out of the shipping dock, and in and out of the doors. However, Petitioner alleged that he can no longer carry out these duties, based on the permanent restrictions placed on him. (T. at 38-39). As the surveillance footage showed him lifting, carrying, pushing and pulling a treadmill and large boxes, some doubt is cast on the restrictions. The Arbitrator gives little weight to this factor. (RX 5-7).

(iii): Age At The Time Of Injury

Petitioner was 27 years old on the date of the 7/13/15 accident. Although he is young, the surveillance footage shows that he can carry out his normal daily activities. The Arbitrator places little weight on this factor.

(iv): Future Earning Capacity

Petitioner introduced his paystubs from Minooka Collision Center into evidence. (PX 12). He testified that doing more than what his permanent restrictions are aggravates his back pain and prevents him from working. (T. at 44). Petitioner testified that his permanent restrictions were the basis of his claim that he is unable to return to work for Respondent. (T. at 37). Yet, the surveillance footage shows that he is capable of exceeding his permanent restrictions. (RX 5-7). He is able to lift large, heavy boxes of product at Target and bend down to place them under his cart. (RX 6 at 10:57). He is also able to push, pull, lift and carry a treadmill. (RX 6 at 1:12:24). The Arbitrator further notes that Petitioner obtained his GED by the time of trial and that he is forklift certified, spotter certified, food and safety certified and has a class C driver's license to operate box trucks. (T. at 10). All of these factors serve to enhance the 27 year old Petitioner's earning capacity.

(v): Evidence Of Disability Corroborated By The Treating Medical Records

The 5/19/16 FCE results indicated that Petitioner's capabilities included:

a. Working for 3 hours per day;
b. Sitting for 3 hours in 30 minute durations;
c. Standing for 1 hour in 10 minute durations;
d. Walking 1-2 hours for occasional distances;
e. Occasionally lifting 17 pounds above the shoulder;
f. Occasionally lifting 25.8 pounds from the desk to the chair;
g. Occasionally lifting 10.4 pounds from the chair to the floor;
h. Occasionally carrying 22 pounds with his right hand;
i. Occasionally carrying 17 pounds with his left hand. (RX 3; PX 6).

Although the medical records indicate that Petitioner is only capable of performing activities within his permanent restrictions, the surveillance footage clearly contradicts the allegation that Petitioner cannot exceed his restrictions. (RX 5-7). Nevertheless, in considering Petitioner's disability the Arbitrator does not doubt that Petitioner has continued pain complaints given his diagnosis and prior surgical consideration. Petitioner testified that he takes prescription medication for the pain, including Norco and Topamax. Petitioner also performs stretching at home. The Arbitrator gives greater weight to this factor. Accordingly, the Arbitrator finds that Petitioner sustained 15% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

In support of the Arbitrator's decision, related to "M," should penalties and fees be imposed upon Respondent, the Arbitrator concludes as follows:

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent's conduct was not so unreasonable, vexatious or without cause so as to mandate the imposition of penalties or fees under the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PLATA, BRANDON A
Employee/Petitioner

Case# **15WC024075**

15WC024074

DOLLAR TREE DISTRIBUTION
Employer/Respondent

18IWCC0158

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:

1987 RUBIN LAW GROUP LTD
CATHERINE K DOAN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

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

18IWCC0158

STATE OF ILLINOIS)
)SS.
COUNTY OF KANKAKEE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Brandon A. Plata
Employee/Petitioner

v.

Dollar Tree Distribution
Employer/Respondent

Case # **15 WC 24075**

Consolidated cases: **15 WC 24074**

An *Application for Adjustment 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 **Kankakee**, on **May 18, 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 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 **5/22/2015 and July 13, 2015**. Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

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

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

Petitioner's current condition of ill-being *is* causally related solely to the accident of July 13, 2015 through September 22, 2016. SEE DECISION

In the year preceding the injury, Petitioner earned **$42,563.56** ; the average weekly wage was **$818.53.**

On the date of accident, Petitioner was **27** years of age, ***married*** with **1** 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 **$34,456.27** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$34,456.27**.

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

ORDER

Petitioner is not entitled to benefits for the accident of 5/22/15 in case 15 WC 24074. SEE DECISION
The following orders pertain to the accident on 7/13/15 in case 15 WC 24075. SEE DECISION

Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred through 9/22/16 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner temporary total disability of $545.69 per week for a period of 57-3/7 weeks commencing 8/17/15 through 9/21/16. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner $491.12 per week for a period of 75 weeks as Petitioner sustained 15% loss of use of the person as a whole pursuant to 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.

Jacqlyn M. O'Reilly

Signature of Arbitrator

6/24/17

date

JUN 27 2017

FINDINGS OF FACT

The Arbitrator notes that Petitioner presented two consolidated matters for trial. In case 15 WC 24074 Petitioner alleges an accident date of 5/22/15 and in case 15 WC 24075 Petitioner alleges an accident date of 7/13/15. ARB EX 1 and ARB EX 2.

Petitioner attended Lockport High School from approximately 2004 through 2007. He did not graduate from high school. Petitioner testified that he completed a GED. He just completed his GED in April 2017. Petitioner has certifications in spotting and food services. He also has a class C driver's license.

At trial on May 18, 2017. Petitioner credibly testified that he was employed by Respondent on May 22, 2015 as a level 200, or L2, department manager. Prior to May 22, 2015, he had been employed by Respondent for approximately four (4) years. Petitioner testified that he was employed as an L2 department manager for Respondent on July 13, 2015 as well. Petitioner described his job duties as a department manager for Respondent. Petitioner testified that he oversaw the daily functions of the department and the associates. He worked in the shipping department. Petitioner made sure that the correct product was in the correct door and assisted in any task that was necessary for the running of the department. Petitioner testified that he performed lifting and carrying as part of his job duties. The heaviest object that he lifted was a safe, which weighed approximately 120 pounds. On a daily basis he lifted bottles of bleach which weighed between 60 and 70 pounds. Petitioner climbed ladders. Petitioner also reached to stack products and grab objects off the convey belt. Petitioner pushed and pulled pallets. The heaviest object that he pushed and pulled was a pallet weighing approximately 300 pounds. As part of his job duties, Petitioner bent and squatted to pick up boxes. He also stood and walked all day. Petitioner testified that he worked between ten (10) and twelve (12) hours per day. He had two (2) breaks and lunch.

Petitioner testified that he performed all of the job duties prior to May 22, 2015 without any difficulty. Petitioner testified that prior to May 22, 2015 he had not received any medical treatment for his back. Further, he had not sustained any accidents of injuries involving his back prior to May 22, 2015. The Arbitrator notes that Respondent does not dispute accident or notice in either case. ARB EX 1 and ARB EX 2.

The 27 year old Petitioner testified that he was performing his job duties for Respondent on May 22, 2015. On that date he was working in the shipping department at door 54. Petitioner was working on a conveyer belt. A pin popped out causing the boxes to keep coming at Petitioner. Petitioner was hit in the chest by a box. The box pushed Petitioner backwards over the conveyer. Petitioner hyper extended his back. Petitioner experienced pain in his back following the work-related accident of May 22, 2015.

Petitioner testified that he did not seek medical treatment following the work-related accident of May 22, 2015. Petitioner continued to work for Respondent as an L2 department manager. He testified that his back hurt while he performed his job duties for Respondent. Petitioner did not sustain any accidents or injuries between May 22, 2015 and July 13, 2015.

Petitioner testified that he was again performing his job duties for Respondent on July 13, 2015. Petitioner was working at door 39 in the shipping department. He picked up a box of bleach, which weighed approximately 70 pounds. As Petitioner was lifting the bleach, he felt a pop in his back. Petitioner immediately experienced pain in his lower back. Petitioner testified that he had difficulty walking. Petitioner testified that following the July 13, 2015 accident, the pain in his back was worse than following the May 22, 2015 accident.

Following the work-related accident of July 13, 2015 Petitioner sought medical treatment on July 14, 2015. Petitioner was initially examined at Physicians Immediate Care on July 14, 2014. (PX 1). Petitioner provided a history of a May 22, 2015 injury at work when boxes on a roller system caused him to hyperextend his back over a wall of boxes. Petitioner reported that his back slowly improved over time and was significantly better 2 weeks before his visit. He next reported that on July 13, 2015 when he was lifting boxes of bleach weighing 50 to sixty 60 pounds and felt a pop in his back with pain in his back radiating to the right shin. (PX 1). Following exam with abnormal results, Petitioner was diagnosed with lumbar sprain and strain and was released to return to work with restrictions. (PX 1). He had another follow up appointment at Physicians Immediate Care on July 17, 2015 where he was again diagnosed with a lumbar sprain strain and given work restrictions. (PX 1).

Petitioner was examined by his primary care physician, Dr. Connelly, on July 20, 2015. (PX 2). Dr. Connelly recommended Tramdol, physical therapy and an MRI study of the lumbar spine along with light duty restrictions. (PX 2). She also recommended that Petitioner be examined by an orthopedic surgeon. (PX 2). Petitioner underwent the recommended MRI study on July 27, 2015 at Channahon Healthcare Center. (PX 3). The MRI study revealed bilateral spondylolysis at L5 with grade 2 anterolisthesis of the L5-S1 and moderate bilateral foraminal stenosis. (PX 3). Dr. Connelly continued the work restrictions on July 29, 2015. PX 2

Petitioner was examined by Dr. Lorenz at Hinsdale Orthopedic on August 6, 2015. (PX 4). Dr. Lorenz documented the May 22, 2015 and July 13, 2015 accidents. (PX 4). Dr. Lorenz set forth an assessment of thoracic lumbosacral neuritis or radiculitis unspecified and spondylolisthesis. (PX 4). Dr. Lorenz recommended Tramadol and injections. (PX 4). He noted that Petitioner was unable to return to work. (PX 4).

Pursuant to the recommendations of Dr. Lorenz, Petitioner was examined by Dr. Koehn for pain management. (PX 5). Dr. Koehn documented that Petitioner sustained a work-related accident. (PX 5). He set forth an impression of stenosis spinal, lumbar region without neurogenic claudication, lumbar disc displacement without myelopathy, degenerative lumbar lumbosacral disc without myelopathy, lumbosacral spondylosis, lumbago and UNS thoracic lumbar neuritis/radiculitis. (PX 5). He recommended Norco and a transforaminal ESI. (PX 5). Petitioner underwent the ESI on August 20, 2015. (PX 4). The ESI was performed by Dr. Koehn at the L5 and S1 level. (PX 4).

Petitioner had a follow up examination with Dr. Lorenz on August 27, 2015. (PX 4). Dr. Lorenz noted that the ESI did not provide relief to Petitioner and that Petitioner continued to have positive straight leg raise on the right with continued radicular complaints in the right lower extremity. (PX 4). Dr. Lorenz recommended additional physical therapy and that Petitioner remain off work. (PX 4). He stated that if Petitioner failed conservative care, then he would be a candidate for spondylolysis repair and decompression. (PX 4). Dr. Lorenz set forth that the work-related accident aggravated Petitioner's pre-existing condition of spondylolisthesis causing his current condition of ill-being and the radiculopathy. (PX 4).

Petitioner was again examined by Dr. Lorenz on October 12, 2015. (PX 4). Petitioner complained of worsened back pain with physical therapy and was considering fusion surgery. Dr. Lorenz referred Petitioner for dietary consultation and a weight loss program advising that Petitioner lose 30 pounds. (PX 4). He stated that if Petitioner lost weight then he would be a candidate for a fusion at L4-S1. (PX 4). Petitioner continued to have follow up appointments with Dr. Lorenz. (PX 4). Petitioner testified that the weight loss program was not authorized by Respondent. Eventually Dr. Lorenz noted that by March 2016 Petitioner had seen a dietician twice and lost 2 pounds. PX 4.

On May 16, 2016, Dr. Lorenz noted that Petitioner's weight loss efforts continued and that Petitioner continued his complaints of right sided lumbar back pain with radiation numbness and tingling extending down the right leg. He noted that since Petitioner had not lost the required weight his choices were to have the surgery or live with the pain. He chose to live with the pain. Dr. Lorenz ordered an FCE and a return to work under the FCE parameters. Petitioner opted for the FCE and against surgery. Dr. Lorenz ordered the FCE and also referred Petitioner to pain management. (PX 4). He also kept Petitioner off work. (PX 4).

Petitioner underwent the FCE at ATI Physical Therapy on May 19, 2016. (PX 6). The FCE was valid and set forth that Petitioner could work at a light physical demand level. (PX 6). The FCE set forth that Petitioner could lift above the shoulder at 17 pounds occasionally, desk to chair of 25.8 pounds occasionally, chair to floor of 10.4 pounds occasionally and carry 22 pounds on the left occasionally and 17 pounds on the right occasionally. (PX 6). Petitioner could work for 3 hours per day, stand for 1 hour 10 minutes and walk for one to two hours. (PX 6). He was also allowed to sit for 3 hours in 30 minute durations. Petitioner also had physical limitations with balance, bending/stooping, climbing stairs, crawling, crouching, right and left foot repetitive movement, kneeling and squatting. (PX 6). Petitioner's physical capabilities fell below his job requirements which the FCE reflected was at the medium level. (PX 6).

Petitioner was examined by Dr. Lorenz on June 6, 2016. (PX 4). Dr. Lorenz noted that Petitioner had limited range of motion secondary to pain but was ambulating without difficulty. (PX 4). He set forth that Petitioner could return to work at the level of the FCE which Dr. Lorenz noted was permanent light duty work only. (PX 4). He noted a maximum lifting of fifteen pounds. (PX 4). Dr. Lorenz again referred Petitioner to pain management. (PX 4).

On August 1, 2016, Dr. Connelly referred Petitioner to Pain Centers of Chicago for pain management. (PX 2). Petitioner was examined by Dr. Estilo on November 3, 2016. (PX 8). Dr. Estilo noted that Petitioner had back pain as a result of a work-related accident. (PX 8). She set forth a diagnosis of chronic lumbar radiculopathy, lumbar foraminal stenosis, grade 2 and L5-S1 anterolisthesis. (PX 8). Dr. Estilo recommended that Petitioner avoid bending through the waist and lose weight. (PX 8). She recommended an ESI. (PX 8). On November 17, 2016 Petitioner canceled the ESI advising that he no longer wanted the procedure. On a follow up visit with Dr. Estilo and December 8, 2016, the ESI was again scheduled. (PX 8).

On January 24, 2017, Petitioner was examined by Dr. Schmidt for pain management. (PX 9). Petitioner was referred to Dr. Schmidt by Dr. Estilo because Dr. Estilo did not accept Petitioner's new insurance. Dr. Schmidt documented both Petitioners' work related accidents. (PX 9). He stated that Petitioner was a surgical candidate, but that "the neurosurgeons" recommended medication management due to his age. (PX 9). On physical examination, Petitioner had paralumbar tenderness, buttocks tenderness and positive straight leg raises. (PX 9). Dr. Schmidt set forth a diagnosis of degeneration of the lumbar/lumbosacral intervertebral disc, lumbar radiculopathy, spinal stenosis of the lumbar region without neurogenic claudication and lumbosacral spondylosis without myelopathy. (PX 9). Dr. Schmidt recommended Norco, Topamax, Baclofen, weight loss and restrictions pursuant to the FCE. (PX 9).

Petitioner was again examined by Dr. Schmidt on February 14, 2017. (PX 9). On physical examination, Petitioner had positive TTP across the lower back and paralumbar region. (PX 9). Dr. Schmidt refilled Petitioner's medication, encouraged continued weight loss and considered an increase in Topamax. (PX 9). Petitioner continued to be prescribed medication through Dr. Schmidt. Dr. Schmidt noted that Petitioner had started working for a new employer within the FCE parameters.

At the request of Respondent, Petitioner was examined by Dr. Frank Phillips on two occasions. (PX 7). Petitioner was first examined by Dr. Phillips on September 8, 2015. (PX 7). Dr. Phillips reviewed the MRI study from July 27, 2015. (PX 7). The MRI revealed L5-S1 grade 1 to 2 spondylolisthesis and disc desiccation at L4-L5 and L5-S1 and L5-S1 lysis and spondylolisthesis and severe foraminal stenosis bilaterally. (PX 7). Dr. Phillips stated that both the injuries were responsible for aggravating symptoms related to the underlying spondylolisthesis. (PX 7). He recommended additional conservative treatment, including therapy. (PX 7). He stated that Petitioner could be a candidate for a lumbar fusion if Petitioner's condition did not improve. (PX 7).

Dr. Phillips set forth that Petitioner had underlying L5-S1 unstable spondylolisthesis with an aggravation of symptoms related to both the May and July 2015 work injuries. (PX 7). He stated that the work injuries were contributing factors to Petitioner's current condition of ill-being and were based on the objective imaging studies. (PX 7). Dr. Phillips based his opinion that the work injury aggravated a pre-existing condition on the objective findings of the MRI, the description of the accident and the fact that the underlying condition increased Petitioner's risk of a work injury. (PX 7). Dr. Phillips found that the medical treatment provided to Petitioner was reasonable, necessary and related to the work-related accident and recommended more physical therapy and injections. (PX 7). He stated that Petitioner could be a surgical candidate. (PX 7). Dr. Phillips released Petitioner to return to work in a sedentary capacity and to avoid lifting more than fifteen pounds and repetitive bending and twisting. (PX 7).

Dr. Phillips again examined Petitioner on May 12, 2016. (PX 7). On physical examination, Dr. Phillips found that Petitioner had an antalgic gait with difficulty heel walking, limited range of motion, diminished sensation in the right shin and positive straight leg raise. (PX 7). Dr. Phillips set forth that Petitioner had reached MMI with regard to his underlying lumbar condition. (PX 7). He noted that if Petitioner declined surgery then he was at MMI and Dr. Phillips would recommend an FCE to assess validity and Petitioner's functional levels. (PX 7). Dr. Phillips stated that if Petitioner proceeded with surgery, the surgery would be reasonable and related to the injury in question. (PX 7).

Dr. Phillips set forth a diagnosis of L5-S1 spondylolisthesis supported by the objective MRI findings. (PX 7). He stated that if Petitioner chose to proceed with surgery then the surgery would be medically necessary and related to the injury. (PX 7). Dr. Phillips set forth that the treatment to date had been reasonable and necessary. (PX 7). He stated that if Petitioner declines surgery than he had reached MMI. (PX 7). If Petitioner did undergo surgery, then MMI would be based on Petitioner's response to the treatment. (PX 7). Dr. Phillips set forth that Petitioner was at MMI for conservative treatment if he did not undergo surgery or was felt not to be a surgical candidate by his treating physician. (PX 7). Dr. Phillips set forth a restriction of avoiding lifting over fifteen (15) pounds and repetitive bending and twisting. (PX 7). Dr. Phillips set forth that Petitioner's weight did not have a direct relationship to his current condition of ill-being and that the current condition of ill-being was not a direct consequence of Petitioner weight. (PX 7). He stated that Petitioner's weight affected Petitioner's decision making as to whether or not surgery was feasible and may be impairing his recovery given the reluctance of his treating physician to perform the surgery due to Petitioner's weight. (PX 7).

The medical bills from Dr. Estilo (PX 17) and Dr. Schmidt (PX 18) were admitted into evidence. Dr. Estilo's medical bill reflected total charges of $518. (PX 17). The medical bill was paid through Medicaid. (PX 17). The medical bill of Dr. Schmidt reflects total charges of $490. (PX 18). The medical bill was paid through Public Aid. (PX 18). The receipts in connection with the out of pocket payments that Petitioner made were also admitted into evidence. (PX 16). Petitioner paid a total of $433.95 for prescription medication and appointments with his treating physicians. (PX 16).

Petitioner contacted Respondent when he was released with permanent restrictions by Dr. Lorenz. Petitioner contacted Dawn Sutter. Petitioner was not provided with work within his restrictions by Respondent. Respondent did not offer Petitioner vocational rehabilitation services. Rather, Petitioner conducted a self-directed job search. He contacted employers online and dropped off applications for employment. Petitioner documented his job search on forms. Petitioner's job search was admitted into evidence. (PX 11). Petitioner participated in a job search from July 2, 2016 through November 4, 2016. (PX 11). Petitioner was paid TTD through October 20, 2016.

As a result of his job search, Petitioner obtained employment. Petitioner was offered a job with Minooka Collision. Petitioner accepted the position as a front end secretary. Petitioner began work for Minooka Collision at the front desk on November 20, 2016. Petitioner earned $10 per hour and the job was 15 hours per week. The pay stubs from Minooka Collision were admitted into evidence and corroborated Petitioner's testimony that he earned $150 per week. (PX 12). Petitioner testified that the job was within his restrictions. He testified that the job required minimal lifting, carrying, pushing/pulling or physical activity. He answered phones and performed office work and answered phones. He occasionally bent, swept the floor or emptied a light trash can which weighed approximately ten (10) pounds.

Petitioner was interviewed by Edward Pagella on September 7, 2016. (PX 10). Mr. Pagella relied on the FCE since it was valid and recommended by both Dr. Lorenz and Respondent's Section 12 physician, Dr. Phillips. (PX 10). Mr. Pagella opined that based on the restrictions, Petitioner would not be able to return to work as an L2 department manager for Respondent. (PX 10). Mr. Pagella recommended vocational rehabilitation services to assist Petitioner with devising a resume, teaching him job seeking skills and interview techniques and speak to potential employers on his behalf. (PX 10). Mr. Pagella also noted that a GED would be beneficial to Petitioner. (PX 10). Mr. Pagella opined that Petitioner had 4 main barriers to obtaining employment: Limited education and no GED; He was only able to work 3 hours per day; He had permanent medical restrictions; He needed an employer who would tolerate his tattoos and piercings. (PX 10).

The evidence deposition of Mr. Pagella was completed on February 24, 2017. (PX 15). Mr. Pagella testified that Petitioner could not return to his job for Respondent. (PX 15 at 16). Mr. Pagella's opinion was based on the valid FCE. (PX 15 at 17-18). Mr. Pagella stated that Petitioner's job duties for Respondent would constitute a heavy physical demand level. (PX 15 at 18). He based his opinion on the fact that Petitioner's job required him to lift boxes, load trucks and operative a fork lift. (PX 15 at 18). At the time of the report, Mr. Pagella recommended vocational job placement services. (PX 15 at 18-19). Mr. Pagella noted that his vocational rehabilitation plan would have been similar to the job search that Petitioner performed. (PX 15 at 19). He opined that Petitioner, on his own, was able to obtain suitable employment. (PX 15 at 19). Mr. Pagella testified that Petitioner participated in a diligent job search since he was able to obtain employment. (PX 15 at 21). Further, Petitioner applied for appreciate jobs during his job search. (PX 15 at 21).

Mr. Pagella opined that Petitioner's employment with Minooka Collision constituted suitable employment. (PX 15 at 21). He testified that the job was viable and consistent within the labor market, was at a sedentary level and allowed Petitioner to change position during the day. (PX 15 at 21). Mr. Pagella would not recommend further vocational rehabilitation services since Petitioner obtained suitable employment. (PX 15 at 22). On cross exam, Mr. Pagella testified that Petitioner had large spacers in Petitioner's ears creating big holes. PX 15, p. 35. Petitioner testified that Mr. Pagella never told him to cover up his tattoos or take out his piercings because they might be a hindrance to his employment. (T. at 40-41).

At trial, Petitioner complained of lower back pain that radiates up the right side and down his right leg. (T. at 32); An occasional limp, depending on how his back feels. (T. at 41-42); Aggravated back pain if he walks, stands or sits for too long. (*Id.*); Aggravated back pain when he lifts his 2 year old son, who weighs approximately 28 pounds. (T. at 43). "It kills [him] every day when [he] can't lift him up."; aggravated back pain when he goes beyond his permanent restrictions, which prevents him from working. (T. at 44).

Respondent submitted surveillance video of Petitioner. (RX 5-7). Surveillance was conducted on September 17-18, 2016, September 22, 2016, September 27-28, 2017 and November 19, 2016. (RX 5-7). The Arbitrator watched all of the surveillance video. On September 17, 2016, Petitioner was not observed. (RX 5). On September 18, 2016, Petitioner left the house on several occasions. (RX 5). The many occasions, Petitioner was behind a car and the Arbitrator could not observe anything. (RX 5). On one occasion, Petitioner exited his house, retrieved an object and walked back to his house. (RX 5).

On September 22, 2016, Petitioner went to a gas station. (RX 6). Petitioner then went to Target for approximately 1.5 hours with his family and a friend. (RX 6). While entering the store, Petitioner carried his toddler child. (RX 6). At the time of the hearing, Petitioner testified that his son weighed 28 pounds. The surveillance took place in September 2016, almost eight (8) months prior to the hearing. Petitioner also shifted the child from arm to arm while carrying him into the store. (RX 6). Petitioner and the group are depicted shopping in Target. Petitioner pushed the cart or walked behind it while in the store. (RX 6). Petitioner is seen vertically lifting and maneuvering several large boxes which appear to be shelving or furniture and carrying two of these boxes to the cart where he bent down to the ground and loaded the boxes onto the bottom of the cart. The boxes appeared to be heavy. (RX 6). Petitioner did squat to load the cart and maneuver the boxes in place. (RX 6). The Arbitrator did not view any pain behavior following this activity. Petitioner carried bags of items to the car, shifted items in the back of his Dodge Ram 1500 truck and then loaded the boxes into the back of the truck. On September 27, 2016, put gas in his truck. (RX 6).

On September 28, 2016, Petitioner went to McDonalds. (RX 6). Petitioner also went to the hospital with his wife and child. (RX 6). Petitioner carried his child during the day. (RX 6). Petitioner went shopping at Walmart. (RX 6). He inspected a treadmill. (RX 6). Although the video is difficult to see, it appears that Petitioner climbed the shelf to see something. RX 6 at 14:16. Petitioner is then depicted with two Walmart employees while the treadmill is loaded into the back of his truck. The two men actually lifted the treadmill into the truck but Petitioner is depicted assisting the two men to push the treadmill into the truck. (RX 6). Petitioner is then seen covering the treadmill with a tarp and climbing on the truck to do so. He is also seen jumping off the truck during this process. (RX 6). With the help of another man, Petitioner is then seen maneuvering the treadmill into his house and specifically pushing and pulling the treadmill to get it into the home. (RX 6). Petitioner did not lift the treadmill. The other man pushed the treadmill while Petitioner steadied it and assisted in moving it into the house. (RX 6). The Arbitrator notes that once the treadmill reached the house, Petitioner cannot be seen on the video. (RX 6).

On November 19, 2016, Petitioner lifted his infant child into the car. (RX 7). He put gas in his car. (RX 7). Petitioner went to Arby's. (PX 7). Petitioner carried his baby through the parking lot. (RX 7). The Arbitrator notes that the child is an infant. Petitioner loaded the truck with a car seat and empty stroller. (RX 7). Petitioner also went to Subway. (RX 7). The Arbitrator notes that at many points during the videos, Petitioner is seen carrying the infant child in a baby seat loading the seat with the baby in the seat into the car and then lifting the seat out of the car. RX 6, RX 7.

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

Avery Tayler,
Petitioner,

vs. NO: 16 WC 04389

18IWCC0159

United Parcel Service,
Respondent.

DECISION AND OPINION ON REVIEW

Petitioner has timely filed a Petition for Review, wherein he requests review of Arbitrator Carlson's order denying reinstatement of his case. Arbitrator Carlson's order was issued orally on June 14, 2017 and reduced to writing on October 17, 2017. The Commission, after considering the record, affirms the Arbitrator's denial of reinstatement. The Commission's findings of fact and conclusions of law are as follows.

1. In February 2016, Petitioner, Avery Tayler, filed an Application alleging a work-related back injury incurred in late 2014. Mr. Tayler was represented at the time by John Harp of Meyers & Flowers. Some months later, a settlement offer was made by Respondent. However, Attorney Harp was unable even to communicate this offer to his client, as Mr. Tayler's phone was disconnected, he had left no forwarding address, and otherwise did not respond to messages left with Mr. Tayler's brother by Attorney Harp as a last resort. (See Attorney Harp's motion to withdraw).

2. Respondent moved to dismiss for want of prosecution, which motion was heard on the record before Arbitrator Carlson on May 5, 2017. During this hearing, Petitioner's counsel explained his due diligence efforts regarding his attempts to reach his client, and he indicated that he had recently filed a motion to withdraw due to Mr. Tayler's non-responsiveness. Arbitrator Carlson granted Respondent's motion to dismiss for want of prosecution that day. The Arbitrator stated on the record that the 60-day period for filing for reinstatement began running that day.

3. On May 23, 2017, Attorney Harp, whose motion to withdraw was still pending, timely filed a Petition to Reinstate, apparently in an abundance of professional caution.

4. On June 14, 2017, the parties argued this reinstatement motion before Arbitrator Carlson, who orally denied the reinstatement at the hearing's conclusion. Unfortunately, this June 14, 2017 hearing was not transcribed, nor did Arbitrator Carlson sign any written order that day.

5. On July 13, 2017, Attorney Harp, again in an abundance of professional caution, subsequently filed the instant Petition for Review, seeking review of Arbitrator Carlson's June 14, 2017 oral denial of reinstatement. In response, on September 13, 2017, Respondent filed a Motion to Dismiss the Petition for Review (hereinafter referred to as "Motion to Dismiss PFR").

6. On October 17, 2017, the parties' attorneys appeared before Commissioner Luskin regarding the Motion to Dismiss PFR. At that time, Commissioner Luskin denied Respondent's Motion to Dismiss PFR and continued the matter to November 15, 2017.

7. Also on October 17, 2017, Arbitrator Carlson reduced his denial order to writing by signing the "Notice of Motion and Order" form that had accompanied the May 23, 2017 reinstatement petition filed by Attorney Harp.

8. On November 15, 2017, the parties' attorneys returned before Commissioner Luskin, who at that time granted Attorney Harp permission to withdraw. The Commission has received no communication from Mr. Tayler subsequent to his attorney's withdrawal.

Discussion

The granting or denying of a petition for reinstatement rests in the sound discretion of the Commission; the standard is the same whether the dismissal takes place at arbitration or on review. Bromberg v. Industrial Commission, 97 Ill.2d 395 (1983). Given Mr. Tayler's longstanding lack of responsiveness to counsel's attempts to communicate with him and his failure to otherwise participate in moving his case forward, Arbitrator Carlson's May 5, 2017 dismissal for want of prosecution was appropriate.

Moreover, and in any event, the Commission finds that Attorney Harp's May 23, 2017 Petition to Reinstate falls short. On the Petition to Reinstate Case form, the attorney wrote, as support for this petition:

> "Attorney for the Petitioner attended all hearings and status calls. Attorney for the Petitioner requested that this matter be continued until June 5, 2017 status call as Motion to Withdraw was set for this date. Matter was dismissed over the objection of the Petitioner's Attorney."

This is unsatisfactory. A petition to reinstate requires the petitioner to allege and prove facts based on the relief requested, and must satisfy the sound discretion of the Commission. *See, e.g.*, Cranfield v. Industrial Commission, 78 Ill.2d. 251, 255 (1980). What Attorney Harp offered appears to go more towards his desire to demonstrate that he had exercised due diligence prior to his withdrawal of representation.

In short, the Arbitrator's dismissal for want of prosecution was reasonable and appropriate, as was the subsequent denial of reinstatement.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's order denying reinstatement, issued orally on June 14, 2017 and reduced to writing on October 17, 2017, is affirmed.

No bond is required for removal of this cause to 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: MAR 19 2018

Joshua D. Luskin

Charles J. DeVriendt

Kevin W. Lamborn

o-01/17/18
jdl/ac
68

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LES SIEFERT,

Petitioner,

vs.

NO: 15 WC 8375

UNIVERSITY OF ILLINOIS,

18IWCC0160

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 permanent partial disability (PPD), 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. 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.

In his Decision, the Arbitrator applied the facts to Section 8.1(b) of the Act in arriving at 2% loss of use of the person as a whole for Petitioner's vertigo condition. However, it is not clear how the Arbitrator reached the award of 2% loss of use of the left ear for Petitioner's hearing loss.

The Commission finds that the Arbitrator's award for Petitioner's vertigo condition is inadequate given the nature and extent of Petitioner's injuries in this claim, and further finds that the Arbitrator did not properly compute the nature and extent of Petitioner's hearing loss as provided for in Section 8(e)16 of the Act.

In considering Section 8.1(b) of the Act, the Commission finds:

(i) Impairment Rating: The Arbitrator afforded no weight to this factor as neither party offered any evidence or opinion relative to impairment.

(ii) Occupation of Injured Employee: The Arbitrator gave some weight to this factor. The Arbitrator noted that Petitioner was a union pipefitter whose work was nonetheless accommodated by Respondent although Petitioner had no restrictions. The Arbitrator also considered Petitioner's testimony that he would have a tougher time working as a pipefitter for private contractors.

(iii) Petitioner's Age: Petitioner was 38 years old on January 16, 2015, and not 39 years old as indicated by the Arbitrator. The Arbitrator did not provide a specific weight to this factor, but noted that Petitioner had to work with his "untreatable vertigo condition" for a longer period of time. The Commission finds that this factor should have been given more weight.

(iv) Petitioner's Future Earning Capacity: The Arbitrator stated that the injury did not affect Petitioner's future earning capacity. In fact, Petitioner testified that he is earning more now than at the time of the accident because he had received a raise. No weight should be given to this factor.

(v) Evidence of Disability: The Arbitrator gave greater weight to this factor, noting that evidence of disability was corroborated by the treating medical records and that Petitioner had testified to ongoing pain. Specifically, Petitioner testified that he experiences vertigo at least once a month; with each episode lasting four to eight hours. The vertigo would make Petitioner vomit and impacted his ability to work; Petitioner does not do as much welding as he used to do prior to the accident date. He also noticed a heightened sensitivity to light.

Based on the above, the Commission finds an award of 7.5% loss of use of the person as a whole more appropriate for Petitioner's vertigo condition. The Commission finds that the Arbitrator gave insufficient consideration to the above fifth (v) factor when considering the impact of Petitioner's vertigo on his daily life and work activities. Though transient, vertigo can be extremely debilitating and impacts negatively upon the Petitioner's quality of life.

As to Petitioner's hearing loss, the Commission finds that the most recent hearing test in the record, completed on August 10, 2016, was the proper test to use to calculate the nature and extent of Petitioner's hearing loss. Using the average decibels recorded at the August 10, 2016 hearing test, the calculation for occupational hearing loss, pursuant to Section 8(e)16 of the Act, is as follows:

1. (55 + 60 + 55 = 170)
2. 170/3 = 56.67
3. 56.67 – 30 = 26.67
4. 26.67 x 1.82 = 48.54% (54 x .4854 = 26.21 weeks)

18IWCC0160

Thus, the Commission finds that the nature and extent of Petitioner's hearing loss is 48.54% or 26.21 weeks.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed June 12, 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 37.5 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused 7.5% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 26.21 weeks, as provided in Section 8(e)14 of the Act, for the reason that the injuries sustained caused 48.54% hearing loss.

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 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: MAR 19 2018

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/pm
D: 3-6-18
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SIEFERT, LES
Employee/Petitioner

Case# **15WC008375**

UNIVERSITY OF ILLINOIS
Employer/Respondent

18IWCC0160

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:

1727 LAW OFFICES OF MARK N LEE LTD
KEVIN MORRISSON
1101 S SECOND ST
SPRINGFIELD, IL 62704

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

0522 THOMAS MAMER & HAUGHEY LLP
ERIC S CHOVANEC
30 E MAIN ST SUITE 500
CHAMPAIGN, IL 61824

1073 UNIVERSITY OF ILLINOIS
OFFICE OF CLAIMS MGMT
100 TRADE CENTER DR SUITE 103
CHAMPAIGN, IL 61820

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

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

JUN 12 2017

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

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
NATURE AND EXTENT ONLY

LES SIEFERT,
Employee/Petitioner

v.

UNIVERSITY OF ILLINOIS,
Employer/Respondent

Case # 15 WC 008375

Consolidated cases: N/A

18IWCC0160

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 **Edward Lee**, Arbitrator of the Commission, in the city of **Urbana**, on **April 12, 2017**. By stipulation, the parties agree:

On the date of accident, January 16, 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 $94,572.63, and the average weekly wage was $1,818.79.

At the time of injury, Petitioner was **39** years of age, ***married*** with **2** dependent children.

Necessary medical services will be paid by Respondent.

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

ORDER

Respondent shall pay Petitioner the sum of $735.37/week for a further period of 10 weeks, as provided in Section 8d2 of the Act, because the injuries sustained caused 2% LOU of a MAW.

Respondent shall pay Petitioner the sum of $735.37/week for a further period of 1.08 weeks, as provided in Section 8(e)12 of the Act, because the injuries sustained caused 2% LOU of a hearing to his Left Ear.

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.

Edwd Lee — Signature of Arbitrator

6/9/17 — Date

Petitioner is a union pipefitter who works for the University of Illinois. On January 16, 2015, he was placing a weld when he felt a hot piece of metal slag enter his left ear which caused immediate pain.

Petitioner's employment as a union pipefitter requires him to weld, use heavy machinery and powered tools, and work above ground level.

Petitioner presented to Convenient Care on January 17, 2015, stating he had hurt his left ear while welding and a hot metal piece flew into his left ear. Petitioner complained of drainage, pain, headache, muffled hearing. Petitioner was referred to Dr. Novak.

Petitioner followed up with Dr. Novak on January 27, 2015 with less pain, muffled hearing, but increasing tinnitus in the left ear. Dr. Novak wanted to wait four to six weeks for the eardrum to heal. If it did not heal they would pursue left tympanoplasty.

Petitioner returned on February 24, 2015 with no change in hearing since his last visit. But Petitioner complained of mild unsteadiness. Dr. Novak was conserved at that time that Petitioner damaged to the cochlea and vestibular system. At that time Dr. Novak ordered that Petitioner proceed with a tymanoplasty.

Petitioner underwent the tympanoplasty on March 10, 2015. It was noted there was a large amount of scar tissue in the middle ear in the posterior superior quadrant.

On April 2, 2015, Petitioner followed up with Dr. Novak. Petitioner had 2-3 days of reported vertigo after the surgery but at that time it had stopped. Petitioner still had hearing loss reported and was told to return in two months for a hearing test.

Petitioner returned on June 9, 2015, with some improved hearing but still had problems with hearing speech. Petitioner was told his condition should continue to improve.

Petitioner underwent an audiology exam on July 8, 2015. Petitioner complained of balance issues, Petitioner becomes nauseous when driving car, sometimes movement makes him dizzy and can last from a few hours to a few days.

Petition returned on 1/19/2016 with no complaints of pain but still complaints of unsteadiness when rotating his head to look under something at work. Not true spinning vertigo but an unsteadiness. Petitioner was then to undergo physical therapy.

On March 24, 2016, Petitioner had been doing physical therapy but still had some episodes of unsteadiness. Petitioner denied spinning vertigo with nausea but

more of a disorientation in a vertical direction. Dr. Novak attempted medication but did not feel that Petitioner may be suffering from chronic inner ear damage.

There are a number of calls noted in Petitioner's medical of them calling complaining of dizziness at work and various medications attempted by his physicians.

On May 26, 2016, Petitioner returned to Dr. Novak with continued occasional episodes of left ear fullness and balance disorder. The episodes occurred once a month and are unpredictable. Dr. Novak believed it to be a bizarre problem but that it was caused by the hot slag injury. Dr. Novak believed there were no good treatment options at that point and hoped the injury would become less severe over time.

On July 28, 2016 with reported with one episode of fullness in the left ear by about 12 hours of vertigo.

Petitioner was then evaluated by a hearing aid specialist on 8/11/2016. It was suggested he would eligible for hearing aids. Petitioner has not gotten them thus far but would like to in the future. His hearing again was tested on this date of treatment.

On the date of trial Petitioner stated he had a dizziness episode that actually caused him to get physically ill. Petitioner stated throughout this time he has worked full duty for Respondent and they have treated him very well. However, based upon his work experience he would have a hard time working outside the field of respondent with sporadic problems like he is currently suffering. Petitioner still welds but not nearly as much as he once did due to his condition and has to occasionally take a day off work. Petitioner also has trouble hearing people taking which impacts his ability to work.

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

The Arbitrator takes note of Section 8.1(b) which sets forth the criteria for determining permanent partial disability.

1) The parties did not submit an impairment rating.

2) Petitioner is a union pipefitter. Throughout his injury Petitioner continued to work full duty and his condition was be accommodated by the Respondent. However the Petitioner testified, credibly that in the private sector he would have a tougher time with private contractors as a pipefitter. The Arbitrator affords this factor some weight which weight.

3) The employee was 39 years old at the time of his injury. Since he is an younger individual he has a long period of work to continue with his, to date, untreatable vertigo condition.

4) This injury did not affect the employee's future earning capacity.

5) The Petitioner's ongoing subjective complaints were corroborated in the medical records. Petitioner is still having on-going pain that he has reported consistently. Therefore, the Arbitrator affords this greater weight..

Based on the above, the Arbitrator concludes Petitioner sustained 2% loss of under §8(e)12 of the Act.

Based on the above on a MAW basis the Arbitrator also awards 2% loss of use.

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

BRANKO BORICICH,

Petitioner,

vs. NO: 14 WC 11473

FORD MOTOR COMPANY,

Respondent.

18IWCC0161

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 disability, medical expenses, and permanent disability, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds Petitioner's condition of ill-being is causally connected to his work accident.

FINDINGS OF FACT

Petitioner worked as an assembler in the body shop of Respondent's Chicago facility where he built "T-bones"; a T-bone, which goes in the middle of the vehicle door, is five feet tall by five feet wide and weighs approximately 20 pounds. T. 14. The T-bone station involves lifting two pieces into the robotic welder, activating the machine, then lifting the completed part out and hanging it up. T. 14. Petitioner assembled 600 to 700 T-bones per shift. T. 14.

Petitioner alleges he sustained a work injury on March 10, 2014 when he slipped on a small part on the floor. He described the incident: "The average shift, we walked probably 12 miles; so I was walking from station to station and I didn't see it and I stepped on it." T. 15. Petitioner testified that when he stepped on the part with his left foot, he heard a pop and felt pain in his left knee. T. 16. He pressed the medical button at the station then went to Plant Medical. T. 16.

The records from the Ford Occupational Health and Safety Information Management System reflect Petitioner presented for evaluation after he "slipped on a piece of equipment used for Taurus t bone." Petitioner was examined by Tyonna Gilbert, RN, who documented Petitioner ambulated with a limp. The nurse diagnosed a left knee contusion, dispensed two Motrin and an Ace wrap, and sent Petitioner back to work with the proviso he should return to the medical department if needed. PX1.

Petitioner testified he resumed his shift but was in pain and had difficulty straightening his knee, so he went back to Medical. T. 17. The records demonstrate Petitioner returned to the plant clinic approximately two and a half hours after his initial visit and advised Nurse Gilbert the Motrin had not alleviated his knee pain. Petitioner was authorized off work for the balance of his shift and instructed to report to Medical on March 14, 2014 prior to starting work. PX1.

Over the next few days, Petitioner's knee remained painful and swollen, and he made an appointment with Dr. David Raab of Illinois Bone & Joint Institute. T. 18. Petitioner testified Dr. Raab treated his knee in the past, as had Dr. Charles Bush-Joseph. T. 20, 21. The records from this prior treatment are in the transcript and demonstrate Petitioner first consulted with Dr. Bush-Joseph on April 17, 1996. The doctor's note reflects Petitioner complained of left knee instability occurring once or twice every month. He provided a history of injuring his left knee 12 years prior while playing basketball; he underwent arthroscopic surgery and had a subsequent repeat injury. Petitioner reported he still played basketball pretty avidly and had instability episodes while playing as well as when walking down the street; he additionally complained of intermittent catching and clicking. Examination revealed minimal effusion, positive Lachman, and a Grade 1 pivot shift test. Dr. Bush-Joseph diagnosed a left ACL tear and recommended x-rays to determine if there were any degenerative changes which could influence repairing or reconstructing his ACL. RX2.

The next time Petitioner saw Dr. Bush-Joseph was February 11, 1998. The doctor noted his last evaluation of Petitioner, performed a year and a half prior, revealed findings of chronic ACL tear of the left knee; over the ensuing months, Petitioner continued to participate in sports and experienced occasional episodes of giving way. Petitioner advised the doctor he wished to proceed with reconstruction. RX2.

On March 12, 1998, Dr. Bush-Joseph performed left knee arthroscopy, partial medial meniscectomy, and anterior cruciate ligament reconstruction with four-strand hamstring technique. The post-operative diagnosis was chronic ACL insufficiency and medial meniscal tear. RX2.

Petitioner followed with Dr. Bush-Joseph post-operatively. On March 13, 1998, the doctor directed Petitioner to commence physical therapy. RX2. As of March 20, 1998, Petitioner was to begin full weightbearing. RX2. On May 1, 1998, Petitioner was noted to be progressing well and by June 12, his range of motion was equal bilaterally. RX2.

When Petitioner next saw Dr. Bush-Joseph on September 11, 1998, he was doing well with the exception of the loss of ten degrees of flexion, down to 115 degrees. Dr. Bush-Joseph recommended increasing Petitioner's activity level to improve his flexion; if that was

unsuccessful, arthroscopic debridement would be considered. RX2.

Petitioner was re-evaluated by Dr. Bush-Joseph eight months later, on May 7, 1999. Petitioner's graft had apparently stretched out somewhat, but Petitioner was overall doing well and had returned to almost all sports including basketball. His major complaint was loss of flexion: he could flex to 120 degrees on the left as opposed to 135 degrees on the right. Dr. Bush-Joseph advised arthroscopy and debridement was an option but warned there was no guarantee Petitioner would improve nor significantly maintain increases in flexion. Petitioner indicated he would consider it. RX2.

On October 8, 1999, Petitioner returned to Dr. Bush-Joseph and gave a history of feeling good, playing basketball on a regular basis, until two weeks prior when he felt a cutting and twisting injury. Dr. Bush-Joseph suspected a re-rupture of the graft or a meniscal tear and ordered an MRI. An October 14, 1999 chart note by Dr. Bush-Joseph indicates the doctor spoke with Petitioner and informed him his MRI revealed a partial re-tear of the ACL and Petitioner would be making an appointment to discuss treatment. RX2. At arbitration, Petitioner did not recall Dr. Bush-Joseph ordering an MRI, nor having that diagnostic done, but did not disagree with what is documented in the records. T. 46. Petitioner did not return to Dr. Bush-Joseph after October 8, 1999. T. 47. Petitioner testified he did not receive left knee treatment after the visits with Dr. Bush-Joseph until he saw Dr. Raab a decade later. T. 47-48.

The next record of medical treatment is over 10 years later: on June 25, 2010, Petitioner presented to Dr. Raab for evaluation of left knee pain. Petitioner explained he consulted with the doctor because his knee was sore and would occasionally swell. T. 18-19. The records reflect Petitioner provided a history of left knee problems dating back to 1988 when he tore his ACL while playing basketball. He subsequently underwent arthroscopic surgery for his knee, but it was not until 1998 that the ACL was reconstructed by Dr. Bush-Joseph. Petitioner rehabbed for nine months and at that time, Dr. Bush-Joseph advised he had some early degenerative changes. A year later, in 1999, he re-tore his ACL but did not have it revised; he had been ACL deficient since but continued to play basketball and remained very active. Petitioner reported he just lived with the pain "until recently he went and saw Dr. Rhode who gave him physical therapy for two months, a cortisone injection which only gave him two weeks of relief." When asked about this notation in Dr. Raab's record, Petitioner testified he recalled seeing Dr. Rhode but not undergoing that treatment; he did not, however, question the accuracy of the record. T. 48. Dr. Raab's physical examination findings included trace effusion, range of motion from zero to 125 degrees, medial joint line tenderness, positive McMurray medially localized, equivocal lateral joint line tenderness, positive patellofemoral crepitus and grind, and trace Lachman with trace pivot shift; x-rays revealed bone on bone in the medial compartment with degenerative changes of the lateral compartment and patellofemoral joint. Dr. Raab diagnosed degenerative arthritis left knee, ACL deficient. The doctor recommended Voltaren as well as a Synvisc injection, which he administered; Petitioner was to return in one month if his symptoms were not improved. The doctor also noted he discussed the possibility of total knee arthroplasty with Petitioner. PX2.

On September 3, 2010, Petitioner returned to see Dr. Raab. The office note indicates the purpose of the visit was follow up evaluation of the left knee and to discuss left total knee

arthroplasty. Petitioner reported the Synvisc injection provided a month of relief then his symptoms returned; he complained of difficulty walking and stated the pain was affecting his daily activities and quality of life. Dr. Raab noted he had a lengthy discussion with Petitioner regarding left total knee arthroplasty; surgery was to be scheduled at Petitioner's convenience pending medical clearance. PX2. At arbitration, Petitioner agreed he and Dr. Raab had a lengthy discussion regarding total left knee replacement but disagreed Dr. Raab had recommended proceeding at that visit; Petitioner testified the doctor "recommended it at some point in time, not then." T. 50-51. Petitioner stated he did not proceed with the knee replacement because "I didn't think I needed it, and he really didn't think I needed it either." T. 20. Petitioner explained he did not feel it was needed because it "just wasn't that bad…I understood that you can - - a patient like me, if you have pain, you can withstand the pain until you can't stand it anymore, you know; and most knee patients had the surgery much later in life." T. 20. At that time, Petitioner was able to tolerate the pain. T. 21.

No further knee treatment is documented until after the alleged March 10, 2014 work accident. Petitioner testified that over those years, he remained physically active and continued to play basketball. T. 51. Between 2010 and 2014, he did not miss any time from work due to left knee pain and he was not taking any medication for knee pain. T. 23, 32.

Petitioner's employment with Respondent began in October of 2012. T. 12. Prior to being hired, Petitioner was required to pass a pre-employment physical. T. 12. This was completed on September 26, 2012. As part of this process, Petitioner completed a health history form. T. 53. Item 17 on this form asks the preparer to indicate whether or not s/he has or had any of the listed conditions/complaints; Petitioner marked "No" to "Bone or joint deformity": "Operations"; "Rheumatism, arthritis, bursitis"; "Swollen or painful joints"; and "'Trick' or 'locked' knee." Petitioner also marked "No" to "Have you ever been hospitalized?" and "Have you ever been advised to have an operation?" On Item 20, Petitioner denied ever having been limited or restricted because of his health. On Item 25, Petitioner responded "Yes" to "Have you received medical attention in the last 5 years?" and indicated it was for a sprained ankle; he did not note his 2010 left knee treatment with Dr. Raab.

At trial, Petitioner was questioned regarding his responses on this form. Petitioner testified he denied having a bone or joint deformity because he does not have any bone or joint deformities. T. 74. Asked why he checked "No" in response to whether he had any operations, Petitioner stated, "I really don't know. I'm just assuming I overlooked that as I certainly have had an operation or two. Maybe I didn't read it properly. I'm not sure." T. 74-75. Asked to explain his response to Question 19, whether he had ever been advised to have an operation, Petitioner responded, "Yeah because, when I thought of my meeting with Dr. Raab, my understanding was he didn't advise me I had to do surgery…I could have it whenever I wanted it, whenever I felt I needed it; but he also said it's mostly for older people; so the longer you can wait, the better it is." T. 75. Regarding Question 25, and his notation of an ankle sprain but not anything else, he stated, "I just really didn't think it was medical attention, I guess. I had severely sprained my ankle not long prior to that. That's what was on my mind. That's why I put that down." T. 76.

As to the physical examination conducted on September 26, 2012, Petitioner testified his

ability to make small movements was tested, including "reaching for things and squatting and things to that nature." T. 13. The Clinical Evaluation reveals Petitioner's physical examination findings were all within normal limits with the exception of his visual acuity. Additional testing included a substance abuse screen and an audiogram. The Ability Assessment completed by Dr. Rashonda Collins indicates Petitioner had no restrictions. PX1. Petitioner stated his left knee did not affect his work performance in the entire time he worked for Respondent. T. 24.

On March 12, 2014, Petitioner consulted with Dr. Raab. Prior to seeing the doctor, Petitioner completed a medical history form. Under History of Present Illness, he wrote, "slipped on a piece of plastic at work." He further marked it was a "work injury" and date of injury was March 10, 2014. He indicated symptoms of "sharp pain" in the left knee; severity was moderate and severe. Duration was noted to be "constant" and also "intermittent." Petitioner responded "Yes" to the question, "Have you had a problem with this area before?" He noted "had an ACL tear 20 years ago" but did not note problems in 2010. Petitioner indicated he had not had diagnostic tests and marked "No" in response to "Has a physician recommended that you have surgery for this problem?" Where it asks to identify previous treating physicians, Petitioner left the space blank. On page two, Petitioner marked "No" for all symptoms listed, including the musculoskeletal category which is described as "Joint, muscle, neck or back pain."

Petitioner was questioned about his responses on this form. Asked what his understanding was of the question if he "had any diagnostic tests for this problem," he responded, "For, you know, when I got hurt, for the accident. I wasn't thinking years prior." T. 79. As to listing the name of previous treating physicians, Petitioner testified the only physician he saw between the accident and the evaluation with Dr. Raab was at Plant Medical. T. 80. Petitioner disagreed a doctor reviewing the medical history form would have no idea he had significant knee complaints four years prior, and noted the form was being completed for the same physician who treated those knee complaints, and he had no reason to believe Dr. Raab did not recall treating him in 2010. T. 81, 87.

The note from Dr. Raab's March 12, 2014 evaluation of Petitioner documents Petitioner complained of left knee pain after an injury at work on March 10. Petitioner reported he slipped on a part and his knee twisted inward; he thereafter developed pain and swelling medially. Petitioner additionally indicated he had recent intermittent episodes of knee pain. Dr. Raab's physical examination findings included effusion, positive patellofemoral crepitus and grind, medial joint line tenderness, and positive McMurray medially localized; x-rays revealed bone on bone in the medial compartment, degenerative changes of the patellofemoral joint, and evidence of previous ACL reconstruction. Dr. Raab diagnosed left knee degenerative arthritis, status post left ACL reconstruction, and left knee injury. The doctor noted a cortisone injection was considered but deferred; Dr. Raab instead prescribed Voltaren and restricted Petitioner to seated work only. Petitioner was to follow up in one week. PX2. Petitioner testified he provided the restrictions to Respondent. T. 25.

On March 19, 2014, Petitioner was re-evaluated by Dr. Raab. Petitioner advised the Voltaren was not effective and his knee symptoms were affecting his daily activities and quality of life. Examination findings were unchanged. Surgical versus nonsurgical options were discussed, and Dr. Raab recommended proceeding with total knee arthroplasty which was to be

scheduled pending workers' compensation and medical clearance. In the interim, Petitioner was to continue the Voltaren and remain restricted to seated work only. PX2. Petitioner testified he pursued surgery at that time and explained why: "I never felt that pain like that. It would get sore and stuff, but not that type of pain...when it initially happened, there was a pop and like a shooting pain like a knife, a shooting pain; and it was hard putting weight on it." T. 26-27. Petitioner stated he had not had trouble putting weight on his left knee in the two to three years prior to his accident. T. 27.

When Petitioner followed up with Dr. Raab on April 9, 2014, he again reported his knee was affecting his daily activities and quality of life. Dr. Raab summarized Petitioner's medical history including the work-related injury on March 10, 2014 as well as the left ACL reconstruction in 1997. The doctor also noted Petitioner had cortisone injections and viscosupplementation in the past but nothing recently. On examination, Dr. Raab again observed effusion, positive patellofemoral crepitus and grind, medial joint line tenderness, and positive McMurray's test. Dr. Raab reiterated his recommendation for left total knee arthroplasty and maintained the seated work restriction until medical clearance and workers' compensation clearance for surgery was obtained. PX2. Dr. Raab made similar findings and recommendations at the May 7, 2014 follow up visit. PX2.

Dr. Preston Wolin performed a record review at Respondent's request and documented his opinions in a report dated May 16, 2014. Dr. Wolin's report indicates he was provided with records of Petitioner's pre-accident treatment with Dr. Bush-Joseph and Dr. Raab, as well as Dr. Raab's office notes from March 19 and April 9, 2014. Dr. Wolin opined Petitioner had osteoarthritis of the knee and the work episode did not aggravate or accelerate his condition:

> On the basis of the records reviewed, it is clear that the subject had established medial compartment arthritis prior to the 3/19/14 (sic) episode. It is also clear that the subject was a candidate total (sic) joint arthroplasty as early as 2010 having failed nonoperative treatment. In fact it was to be scheduled to occur in 2010. Apparently the subject decided not to undergo that procedure. However, since the arthroplasty was already indicated, the 2014 episode could not have been a factor in the need for knee arthroplasty. The work episode did not cause any permanent harm to the subject. RX1.

On July 31, 2014, Petitioner was admitted to Advocate Lutheran General Hospital where Dr. Raab performed a left total knee arthroplasty and removal of hardware. The post-operative diagnosis was osteoarthritis left knee and retained hardware, status post anterior cruciate reconstruction. PX2. Petitioner was off work as of the surgery date. T. 27. Post-operatively, Petitioner attended physical therapy at Accelerated Rehabilitation Center. PX3.

On August 20, 2014, Petitioner had his first post-op evaluation with Dr. Raab. Petitioner was noted to be doing well, taking Norco, and attending physical therapy. Examination revealed range of motion from -5 to 90 degrees and no effusion; x-rays revealed the components to be in good position with no signs of loosening. Dr. Raab ordered additional physical therapy and directed Petitioner continue to take Norco as needed. PX2.

Petitioner attended physical therapy as directed (PX3) and next saw Dr. Raab on September 10, 2014. He reported he was "doing great" and no longer needed Norco. Dr. Raab directed Petitioner to remain off work while continuing with physical therapy. PX2.

The records demonstrate Petitioner underwent physical therapy through October 30, 2014. PX3.

On November 5, 2014, Petitioner was re-evaluated by Dr. Raab. Petitioner described some stiffness, swelling, and slow progress but stated he was overall doing well. Dr. Raab recommended additional therapy and authorized Petitioner to remain off work. PX2. The Commission notes no physical therapy daily records or bills beyond October 30, 2014 were admitted.

At the December 17, 2014 follow up appointment, Dr. Raab noted Petitioner continued to do well and his range of motion had improved to zero to 115 degrees. Dr. Raab directed Petitioner to continue with therapy and released him to restricted work, seated job only. PX2. Petitioner testified he provided the work status note to Respondent but no accommodated position was provided. T. 28-29.

Petitioner started a new job at Pegasus Trading on February 1, 2015; Pegasus is a software and trading company, and he sold software. T. 29-30. The work at Pegasus was lighter than what he did at Respondent. T. 31.

Over the next several months, Petitioner attended regular follow up appointments with Dr. Raab. During that span, Dr. Raab observed Petitioner was improving, but the doctor continued to impose work restrictions. PX2.

On July 8, 2015, Petitioner was re-evaluated by Dr. Raab. At that time, Petitioner was approximately 11 months status post total knee arthroplasty. On examination, Dr. Raab observed there was no effusion and range of motion was steady at zero to 115 degrees; x-rays again demonstrated the components in good position with no signs of loosening. Dr. Raab concluded Petitioner had reached maximum medical improvement, released him to return to work with no restrictions, and discharged him from care. PX2.

On May 18, 2016, Dr. Raab issued a causation opinion. In response to the question whether or not Petitioner's March 10, 2014 accident "caused, aggravated, or accelerated his left knee condition and whether that accident is causally connected to the surgery performed, specifically if I believe his accident did lead to his surgery given the fact that I discussed the same surgery with him approximately four years earlier," Dr. Raab opined as follows:

> Based on the records that I have and the history that this patient gave to me, it does appear that he did sustain a work-related injury on March 10, 2014, and it is my opinion that this more likely than not was an aggravation of obviously of a preexisting degenerative knee. Certainly, I did discuss total knee replacement with him in 2010; however, I did not see him back until spring of 2014. He did present with a work related injury that seems to have affected his

baseline of this degenerative knee; and therefore, I do feel it is causally related. As I stated, it is quite clear on the records that this gentleman did have degenerative arthritis in this left knee dating back to my initial visits in 2010. I did discuss total knee replacement with him at that time as well. This is quite clear in the records. Having stated that, it appears that he tolerated the knee up through March 10, 2014, working in a full duty capacity. It did appear to be work related injury per the patient's history. He was not able to return back to work subsequent to that injury and did undergo knee replacement, therefore, I do feel it is an aggravation of a preexisting condition and therefore causally related. PX4.

CONCLUSIONS OF LAW

Accident

Accident was a disputed issue at arbitration but has not been raised on review. The Commission nonetheless provides a brief analysis of the issue.

In order for an injury to be compensable under the Act, the injury must "arise out of" and "in the course of" the employment. *820 ILCS 305/2*. Generally, an injury arises "in the course of employment" if it occurs "within the time and space boundaries of the employment." *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E.2d 665 (2003). 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. "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." *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 57-8, 541 N.E.2d 665 (1989).

There is no question Petitioner's injury occurred in the course of his employment: Petitioner was in his designated department in the midst of his shift. As to arising out of, Petitioner testified his injury occurred when he stepped on a small part on the floor. The medical records corroborate this description. Given these circumstances, Petitioner's injury originated in an employment risk, *i.e.*, he encountered a hazard while performing his assigned duties. The Commission finds the documentary and testimonial evidence establish Petitioner sustained an accidental injury arising out of and in the course of his employment on March 10, 2014.

Causal Connection

Credibility

The Arbitrator denied causal connection. Prior to doing so, the Arbitrator authored a lengthy section regarding Petitioner's credibility and ultimately found "Petitioner's testimony at trial to be less than fully credible." The Arbitrator highlighted "selective omission of relevant facts on the part of Petitioner in his reporting to Dr. Raab in 2014 and to Respondent in 2012." The specific omissions found damning are the failure to note prior knee problems on his pre-employment Health History form, as well as the March 12, 2014 Medical History questionnaire

Petitioner completed for Dr. Raab wherein he failed to note his prior treatment with Dr. Raab in 2010. The Commission views the evidence differently.

For instance, the Commission finds Petitioner's failure to disclose his knee condition on the 2012 pre-employment Health History questionnaire to be of little relevance to the issue of whether that condition was aggravated by an acute injury in 2014. The Commission is certainly cognizant of the red flags raised when a claimant denies having any pre-existing conditions then sustains an aggravation injury shortly after getting hired. That is not the case here. To be clear, the uncontroverted evidence establishes that upon being hired, Petitioner spent the next 18 months working a physically demanding job, the daily requirements of which included lifting 20-pound parts up to 700 times and walking 10 to 12 miles. Respondent posits this omission renders incredible Petitioner's testimony that his knee condition was tolerable prior to his work accident. The Commission disagrees and notes that if Petitioner's knee complaints were as debilitating as Respondent's argument assumes, it would certainly have been observable to Petitioner's supervisors and coworkers, and some evidence could be produced demonstrating Petitioner struggled to perform his duties or stand/walk. Here, there is no evidence to suggest Petitioner was in any way limited or struggled to perform his required duties.

Additionally, the Commission is not troubled by Petitioner's entries on the March 12, 2014 Health History form. We note not documenting his prior treatment with Dr. Raab on the form is not suspicious. To the contrary, we find it not unusual that an individual would assume his patient file with a physician contains the records of his prior treatment by that physician.

The Commission finds Petitioner was not evasive. While he did not recall making certain complaints, that is not surprising given the amount of time that had passed. Moreover, he did not challenge the accuracy of what was documented in his records. The instance that gives the Commission pause is Petitioner's testimony that he remembered seeing Dr. Rhode but not undergoing physical therapy and an injection. This is certainly unusual yet the Commission notes no records of that treatment were admitted into evidence.

What the Commission finds to be compelling evidence that Petitioner's condition was aggravated is the sudden change in Petitioner's ability work following the accident. The Commission finds *Schroeder v. Illinois Workers' Compensation Commission*, 2017 IL App (4th) 160192WC, 79 N.E.3d 833, to be directly on point.

In *Schroeder*, the claimant was a truck driver. Prior to being hired by the respondent, she had two back surgeries, the first in 2009 and a second in 2011. In January or February 2013, she returned to her treating physician with complaints of back pain and numbness in her feet. The medical records reflect her treating physician was considering a third surgery in March 2013, however the claimant declined the surgery. She took a refresher course in truck driving and obtained a position with the respondent, starting on May 30, 2013. Prior to starting, she underwent a physical examination, at respondent's direction, which she passed, as well as a physical mandated by the Illinois Department of Transportation, which she also passed. From the time she was hired to the date of her accident, the claimant worked full time, unrestricted duty. On the date of accident, she slipped and fell on her back, landing on a concrete pad. She thereafter returned to her treating physician with complaints of back and left leg pain; the

claimant was authorized off work at that time. Her condition continued to worsen over the next three months and on April 10, 2014, a fusion was performed.

The arbitrator found the claimant proved accident but denied causation. The arbitrator first noted the claimant had a long history of severe degenerative disc disease, and the treating physician was concerned about "the evolving and substantial breakdown at L5-S1." The arbitrator also emphasized no objective testing confirmed a change in claimant's condition following the accident, and the surgery performed in April 2014 was the same surgery recommended before the accident, finding it insignificant the surgery was performed using a different methodology. Finding the Section 12 examiner's opinion persuasive, the arbitrator found the accident resulted in only a temporary aggravation of the claimant's pre-existing low back condition.

On review, the Commission reversed. The Commission acknowledged the claimant's substantial preexisting condition but observed the arbitrator failed to note the claimant was able to work full time following the spring of 2013 when the treating physician expressed his concern about her condition. The Commission noted it was undisputed the claimant's condition deteriorated after the accident. It specifically highlighted the claimant's ability to work before the accident and inability to do so after. The Commission criticized the Section 12 opinion to the extent that the doctor felt the claimant's pain was transient. It observed that, to the contrary, the claimant's pain never subsided after the accident. Based thereon, the Commission found the claimant's condition of ill-being was causally related to her accident.

On appeal, the Appellate Court reiterated the well-known principles regarding aggravation of a pre-existing condition: "It is well established that an accident need not be the sole or primary cause—as long as employment is a cause—of a claimant's condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665 (2003). Furthermore, an employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Workers' Compensation Comm'n*, 371 Ill. App. 3d 882, 888 (2007). A claimant with a preexisting condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36 (1982)." *Schroeder*, ¶28. The Court then turned to the respondent's specific challenges; as in the case at bar, the respondent highlighted the similarity in pre- and post-accident objective testing and subjective complaints:

> ...respondent first points to the absence of changes in objective testing such as MRIs and X-rays from before to after the accident. A clear basis in the record existed for the Commission to find such evidence lacks significance. [The treating physician] explained that the correlation between objective changes and symptomatic changes is not always clear, citing his own experience with patients. Thus, the absence of objective evidence does not clearly point to an opposite conclusion. Respondent takes issue with the subjective evidence as well. However, for the most part, it merely identifies conflicts in the record. For example, respondent points to claimant's reports of her pain levels before and after the accident, which did not change significantly. It also points to claimant relating, to another practitioner, descriptions of her condition that were similar to her descriptions before the accident. Such evidence merely creates a conflict with her

> ability to work before the accident and her inability to work following the accident. It is undeniable that claimant had a significant back condition before the accident; it is also undeniable that her ability to work completely deteriorated after the accident. We certainly cannot say that her consistent reports of pain were required to be given more weight than changes in her ability to work. In any event, it was for the Commission to resolve such conflicts in the evidence. *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009). None of them are so significant that we could disregard the evidence supporting the Commission's decision and say that it was against the manifest weight of the evidence. *Schroeder*, ¶30 (Emphasis added).

Here, the Arbitrator stated, "There is simply no evidence that the Petitioner's pre-existing left knee condition was aggravated in any way by the incident of March 10, 2014, and thus no evidence that this incident accelerated his need for a surgery that he had already needed since 2010." The Commission finds this statement is incompatible with the clear evidence of an immediate change in Petitioner's ability to work following the accident.

There is no question Petitioner had pre-existing osteoarthritis in his left knee. There is likewise no question Dr. Raab had a "lengthy discussion" regarding total knee replacement in September, 2010. As the Appellate Court held in *Schroeder*, however, the "salient" factor is the deterioration. It is undisputed no work restrictions were imposed in 2010. It is similarly undisputed Petitioner passed his pre-employment physical in 2012, with no restrictions being imposed, and for the next 18 months, worked a job which required him to walk up to 12 miles per day, a position he was able to perform without difficulty and without the need for treatment. On March 10, 2014, he steps on a part and twists his left knee. He immediately goes to Plant Medical, where the employer's medical staff documents he is "ambulating with a limp"; he is given Motrin and sent back to work but returns with continuing pain complaints just two hours later and is sent home and told to follow up with medical before returning to work. When Petitioner is evaluated by Dr. Raab two days later, the doctor provides Voltaren and restricts him to seated work only. PX2. At the March 19, 2014 follow-up, Dr. Raab recommends total knee arthroplasty and maintains the seated-work only restriction. PX2. This demonstrates a clear deterioration in Petitioner's condition following the work accident.

The statement there is "no evidence" the incident accelerated the need for surgery is also inconsistent with the extended gap in treatment. To be clear, this is not weeks or months between treatment; this is a three-and-a-half-year-gap during which Petitioner sought no treatment and worked unrestricted duty. As Dr. Raab concluded in his narrative report:

> Certainly, I did discuss total knee replacement with him in 2010; however, I did not see him back until spring of 2014…As I stated, it is quite clear on the records that this gentleman did have degenerative arthritis in this left knee dating back to my initial visits in 2010. I did discuss total knee replacement with him at that time as well. This is quite clear in the records. Having stated that, it appears that he tolerated the knee up through March 10, 2014, working in a full duty capacity. It did appear to be work related injury per the patient's history. He was not able to return back to work subsequent to that injury and did undergo knee replacement,

therefore, I do feel it is an aggravation of a preexisting condition and therefore causally related. PX4 (Emphasis added).

The Commission finds Petitioner's condition of ill-being remains causally connected to his work accident.

Temporary Disability

The record reflects Petitioner began missing work on July 31, 2014, the date of his surgery. He remained authorized off work until December 17, 2014; on that date, Dr. Raab released Petitioner to seated work. Petitioner testified he provided the modified duty release to Respondent but no accommodated work was provided. Dr. Raab maintained Petitioner's restricted duty status until July 8, 2015. Petitioner did not, however, remain off work for that entire period; Petitioner testified he started a new job at Pegasus Trading on February 1, 2015. Therefore, the Commission finds Petitioner proved entitlement to 26 3/7 weeks of temporary total disability benefits, representing July 31, 2014 through January 31, 2015.

Medical Expenses

Petitioner submitted medical expenses totaling $68,691.00, covering charges for services rendered at Advocate Lutheran Hospital, Illinois Bone & Joint Institute, and Accelerated Rehabilitation. The Commission finds these expenses were reasonable and necessary for treatment of Petitioner's work-related condition of ill-being. The Commission orders Respondent to pay these expenses pursuant to §§8(a) and 8.2.

Permanent Disability

Petitioner's work accident occurred after September 1, 2011; therefore, Section 8.1b applies. 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) – 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 assigns no weight to this factor and will assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1(b)(ii) – occupation of the injured employee

Petitioner was an assembler in Respondent's vehicle assembly plant. He did not return to

his pre-injury job. There was testimony he chose not to return to Respondent because of the physical demands of the job, but the Commission notes this testimony was elicited in response to why Petitioner did not return to Respondent when Dr. Raab released him to restricted duty on December 17, 2014. The Commission finds Petitioner's perceived limitations eight months prior to achieving maximum medical improvement are not reflective of his ultimate permanent disability. Rather, the Commission emphasizes Dr. Raab imposed no permanent restrictions when he released Petitioner from care, so although Petitioner elected not to return to his pre-injury manual-labor job, there are no residual physical limitations preventing him from performing such work. The Commission places significant weight on this factor as being indicative of reduced permanent disability.

Section 8.1(b)(iii) – age of the employee at the time of the injury

Petitioner was 51 years old on the date of his accidental injury. The Commission notes Petitioner is nearing the end of his work-life and will therefore face his residual disability for a shorter period. The Commission finds this factor weighs in favor of decreased permanent disability.

Section 8.1(b)(iv) - future earning capacity

Given the release to unrestricted work, there is no evidence of a negative impact on Petitioner's future earning capacity. The Commission finds this reflects a reduced permanent disability.

Section 8.1(b)(v) – evidence of disability corroborated by treating medical records

Petitioner underwent a left total knee arthroplasty on July 31, 2014, followed by post-operative therapy. Petitioner testified his pain has resolved but he remains limited with respect to activities he used to perform, such as running and squatting; he also reported difficulty climbing stairs. At his final medical visit, on July 8, 2015, Dr. Raab documented physical examination findings of range of motion from 0 to 115 degrees and no effusion; x-rays showed the components to be in good position with no signs of loosening. Dr. Raab placed Petitioner at maximum medical improvement and released him to return to work full duty. PX2. 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 35% loss of the left leg under Section 8(e)12.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $427.26 per week for a period of 26 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 $384.53 per week for a period of 75.25 weeks, as provided in §8(e)12 of the Act, for the reason that the injuries sustained caused the 35% loss of use of the left leg.

18IWCC0161

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $68,691.00 for medical expenses, as provided in §§8(a) and 8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: MAR 19 2018

L. Elizabeth Coppoletti

LEC/mck

O: 1/17/18

Charles J. DeVriendt

43

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BORICICH, BRANKO
Employee/Petitioner

Case# **14WC011473**

FORD MOTOR COMPANY
Employer/Respondent

18IWCC0161

On 2/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0075 POWER & CRONIN LTD
ADAM RETTBERG
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

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

BRANKO BORICICH
Employee/Petitioner

v.

FORD MOTOR COMPANY
Employer/Respondent

Case # 14 WC 11473

Consolidated cases: ____

18IWCC0161

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

DISPUTED ISSUES

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

FINDINGS

On **3/10/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$33,326.68**; the average weekly wage was **$640.89**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **1** dependent children.

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

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

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

Respondent is entitled to a credit for any and all benefits paid pursuant to its group insurance policy for awarded related medical bills pursuant to Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $327.00 to Illinois Bone & Joint Institute for dates of service 3/12/14 and 3/19/14 as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $384.53/week for 2.15 weeks, because the injuries sustained caused the 1% loss of the left leg, as provided in Section 8(e) of the Act.

Because the Petitioner's condition of ill-being following the injury of 3/10/14 was not causally connected to said injury after 3/19/14, further 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.

Deborah L. Simpson

Signature of Arbitrator

February 1, 2017
Date

FEB 14 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Branko Boricich,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 14 WC 11473**
	)	
Ford Motor Company,	)	
	)	
Respondent.	)	**18IWCC0161**
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on August 11, 2016 the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner gave the Respondent notice of the accident that is the subject matter of this dispute, within the time limits stated in the Act. They further agree that in the year preceding the injury the petitioners earnings were $33,326.68 and his average weekly wage calculated pursuant to Section 10 of the Act was $640.89.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries that arose out of and in the course of the employment; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Is the Respondent liable for unpaid medical bills to Advocate Lutheran , Illinois Bone and Joint and Accelerated Rehabilitation; (4) Is the Petitioner entitled to TTD from July 31, 2014 through January 31, 2015; and (5) the nature and extent of the injury.

STATEMENT OF FACTS

Petitioner Branko Boricich, a 53-year-old at the time of trial, was employed by Respondent Ford Motor Company as of March 2014. (TX, p. 11-12) He first began working for Respondent in October of 2012, at which time he was required to undergo a physical examination, which he completed without difficulty. (TX, p. 12-13). He described his job as that of "assembler," though he did not have a specific job title. (TX, p. 13-14) His specific position was in the body shop, where he worked to assemble a vehicle part called a "T-bone." (TX, p. 14) To assemble this part, he lifted and placed two separate pieces into position so that a robot

welder could join them, and then lifted the finished piece off to a separate position for further assembly. (Id.) He performed this action approximately 600 to 700 times daily. (Id.)

On March 10, 2014, Petitioner was performing this duty in his regular capacity when he slipped on something on the floor. (TX, p. 15) Petitioner testified that the piece he slipped on was a small part approximately 3 inches square that was not from his work area. (Id.) He speculated that it must have been dropped by someone else. (Id.) As he was walking from station to station, he stepped on this item with his left foot and slipped. (TX, p. 15-16) He felt a pop and experienced pain in his left knee. (TX, p. 16) He pushed a medical button at his station and proceeded to the on-site medical clinic. (Id.)

At the plant clinic, he described what had happened and received some Advil. (TX, p. 17) He returned to his station on advice from the clinic to continue his work. (Id.) At his station, he felt that his left knee was too painful to work and could not completely straighten the knee, so he returned to the medical clinic. (Id.) At that point, he went home for the remainder of the day. (Id.)

Over the subsequent two days he continued to experience pain, and noted swelling in the left knee, and made an appointment to see Dr. Raab, whom he had seen in the past. (TX, p. 18) In 2010, he had treated with Dr. Raab between June and September for left knee soreness and swelling. (TX, p. 19) As of the September visit, he had discussed proceeding with a left knee replacement but chose not to at that time. (TX, p. 19-20) He decided against undergoing the surgery at that time because he felt he could withstand the pain, and because most knee replacement patients had the surgery later in life. (TX, p. 20) In addition to the treatment in 2010, Petitioner had previously undergone left knee surgery in 1998. (TX, p. 21) At that time his treating surgeon was a Dr. Bush-Joseph at Rush Orthopedics. (Id.)

Between his treatment with Dr. Raab in 2010 and his employment by Respondent in October 2012, Petitioner worked for another company whose name he could not recall. (TX, p. 22) This work may have taken place in an office environment, though Petitioner was not certain. (TX, p. 22) He also worked for FedEx for approximately half a year in 2010, in a capacity which he described as a "second job." (Id.) At FedEx, he worked in a warehouse stocking mail. (Id.)

Between his left knee treatment in 2010 with Dr. Raab and his alleged injury of March 10, 2014, Petitioner testified that he had not received any left knee treatment from any source, and had not missed any work due to left knee pain. (TX, p. 23) On March 10, 2014, prior to the incident he described, his left knee had felt normal. (TX, p. 24)

On March 12, 2014, Petitioner saw Dr. Raab for the first time since the alleged incident of March 10, 2014. (TX, p. 24-5) Dr. Raab prescribed him medication and set forth light duty restrictions, which Petitioner passed along to Respondent. (TX, p. 25) He returned to Dr. Raab on March 19, 2014, and felt that the medication had not relieved his left knee pain. (TX, p. 25-6) At that visit, Dr. Raab recommended left knee replacement. (TX, p. 26) Petitioner elected this

time to proceed with the surgery because he had "never felt pain like that." (Id.) He described his left knee pain as "like a shooting pain like a knife", and noted difficulty putting weight on the knee. (TX, p. 27) He had not had similar problems within the prior two to three years. (Id.)

Petitioner underwent the recommended left knee replacement with Dr. Raab on July 31, 2014. (Id.) Thereafter he was taken off-work for a period of time. (Id.) He then had a post-operative visit with Dr. Raab on August 20, 2014. (TX, p. 27-8) He began undergoing physical therapy at Accelerated Rehab, also at the recommendation of Dr. Raab. (TX, p. 28) Over the following months he continued to follow up in treatment with Dr. Raab, who released him to light-duty work as of December 17, 2014. (Id.) He presented this light-duty release to Respondent, but was not offered light-duty work. (TX, p. 28-9)

Petitioner took a new job with a company named Pegasus Trading as of February 1, 2014. (TX, p. 29-30) This company was involved in software and trading, and Petitioner's position was in sales. (TX, p. 30) He took this position because he felt he couldn't return to work for Respondent. (Id.) This feeling was based in part on his feelings about his left knee, in which he continued to experience pain and reduced range of motion. (Id.) The work for Pegasus Trading was lighter in nature than the work he had been performing for Respondent. (TX, p. 30-31) He worked for this company for approximately a year, at which time it ran out of funds and went out of business. (TX, p. 31)

Petitioner had a final visit with Dr. Raab on July 8, 2015, at which point he was released from medical care. (Id.) As of that time, Petitioner continued to feel left knee pain and testified that he was "very worried about it." (TX, p. 32)

Petitioner testified that prior to the alleged injury of March 10, 2014, his left knee experienced constant dull pain. (TX, p. 33) After the alleged injury of March 10, 2014, Petitioner stated that he experienced a sharp increase in his level of left knee pain for an unspecified period of time before it subsided. (Id.) He has not sustained any additional left knee injuries since the alleged injury of March 10, 2014. (Id.) As of the time of trial he was not taking any medication for left knee pain. (Id.) He is not presently working and is between jobs. (Id.)

At present, Petitioner's left knee pain is almost all gone, but he cannot run, work out, or play with his kids. (TX, p. 34) While testifying he was able to sit with his knee flexed about 90 degrees, but cannot bend it much further than that. (Id.) At trial, he demonstrated flexion to approximately 100 degrees in the left knee. (TX, p. 34-5) He further testified that Dr. Raab had advised him he "can't run period." (TX, p. 35) He is fearful of performing any work or physical activity that requires squatting or kneeling. (Id.) He previously was able to play catch with his son and play basketball with his daughter, but cannot anymore due to his left knee. (TX, p. 36-7) He has attempted to play basketball, and feels he cannot move the way he used to. (TX, p. 37) Prior to March 10, 2014, he "didn't really even think about" his left knee when playing basketball. (Id.)

At home, he takes stairs slowly using an approach where he places both feet upon the same stair before proceeding to the next. (TX, p. 39) He did not have to do this prior to March 10, 2014. (Id.) At the end of a typical day his left knee feels tired. (Id.)

Under cross examination, Petitioner agreed that Dr. Raab had placed no work restrictions upon him at the time of his final visit on July 8, 2015. (TX, p. 40) He testified that Dr. Raab had told him that he couldn't run. (Id.) Petitioner agreed that he was at no point required to run during his employment with Respondent. (TX, p. 41)

Petitioner testified that he had no reason to doubt the accuracy of the records of his treatment with Dr. Bush-Joseph in 1996 and 1998. (TX, p. 41-47) Petitioner agreed with records showing that he had previously undergone left knee arthroscopic surgery in approximately 1984 (TX, p. 41-2), had sustained an additional subsequent injury to the left knee approximately six months after that (TX, p. 42), underwent left knee ACL reconstructive surgery on March 12, 1998 (TX, p. 44), that evidence of developing left knee arthritis was noted during that surgery (Id.), that he had reported reduced flexion in the left knee on September 11, 1998 (TX, p. 45), that Dr. Bush-Joseph had advised Petitioner he would require further arthroscopic surgery if exercise did not improve his flexion (Id.), and that in May of 1999 he sustained another injury to his left knee playing basketball which a subsequent MRI showed to have been a re-tear of the ACL (TX, p. 46)

Petitioner admitted that he had seen a Dr. Rhode regarding left knee pain sometime recently prior to seeing Dr. Raab on June 25, 2010, in contrast to his prior testimony that he had not seen any physician after Dr. Bush-Joseph until his visit with Dr. Raab. (TX, p. 48) Petitioner did not recall undergoing two months of physical therapy and a cortisone injection to the left knee at Dr. Rhode's order, but did not doubt the accuracy of Dr. Raab's record so reflecting this treatment. (Id.) Petitioner agreed that x-rays taken by Dr. Raab on June 25, 2010 were positive for degenerative arthritis within the left knee, and that they showed "bone on bone" conditions within the knee joint. (TX, p. 49) He agreed that Dr. Raab had discussed the possibility of left total knee replacement with him on June 25, 2010. (Id.)

Petitioner did not recall telling Dr. Raab on September 3, 2010 that his left knee pain was affecting his daily activities and quality of life, but did not doubt the accuracy of the record reflecting these complaints. (TX, p. 50) He agreed that on that occasion he and Dr. Raab had held a lengthy discussion regarding a left knee total replacement. (Id.) He testified that Dr. Raab had recommended the procedure for some unspecified point in time, not at that time. (TX, p. 50-1) He agreed that Dr. Raab had told him that he could schedule the procedure at his convenience at the visit of September 3, 2010. (TX, p. 51)

Petitioner agreed that he had remained physically active between September 3, 2010 and March 10, 2014, and had continued to play basketball during that time. (Id.)

In conjunction with the physical examination he underwent when applying for employment with Respondent on September 26, 2012, Petitioner completed a health history form. (TX, p. 52-3; see also Pet. Ex. 1 p. 34-5) Petitioner agreed that this document bore his signature and that he had completed it personally. (TX, p. 52-3) He agreed that he had answered "no" on the form when asked if he had ever previously experienced bone or joint deformity, had ever had arthritis, had ever had swollen or painful joints, had ever had a trick or locked knee, or had ever been limited or restricted because of his health. (TX, p. 53-5) Petitioner agreed that his additional answers of "no" to the questions on the form asking whether he had ever undergone an operation or had been advised to undergo an operation were not true. (TX, p. 54-5) Petitioner agreed that he had answered "yes" to the question asking if he had received any medical treatment in the prior five years, and that his explanation for this answer had been limited to "sprained ankle." (TX, p. 55) He agreed that he had not mentioned his 2010 left knee treatment with Dr. Raab. (TX, p. 55-6)

Regarding the March 12, 2014 visit with Dr. Raab, Petitioner testified that he did not have reason to doubt the accuracy of the written record of that visit. (TX, p. 57) He agreed that Dr. Raab had taken x-rays at that visit which showed "bone on bone" conditions of degenerative arthritis within the left knee, and agreed that this was the same finding that had been noted at the prior visit of June 25, 2010. (TX, p. 57-8) He agreed that the prescription for a drug called Voltaren provided by Dr. Raab at the visit of March 12, 2014 was the same drug that had been prescribed at the June 25, 2010 visit. (TX, p. 58-9)

Petitioner agreed that he had completed a medical history form at his visit with Dr. Raab on March 12, 2014. (TX, p. 60; see Pet. Ex. 2, p. 69-71) Petitioner agreed that he had completed and signed this form. (Id.) He agreed that in signing the form he had certified that to the best of his knowledge the information he had provided on the form was accurate and complete, as stated above his signature on the form. (Id.) Petitioner agreed that when the form asked if he had ever had a previous problem with the left knee, he had answered "yes" and provided an explanation that he had an ACL tear 20 years prior. (TX, p. 61) Petitioner agreed that his answer did not include any additional information, including the left knee problems he had reported to Dr. Raab in 2010. (TX, p. 61-2) Petitioner agreed that he had answered "no" when asked if he had had previous diagnostic tests on the left knee, and that this answer made no mention of the x-rays he had undergone in visiting Dr. Raab in 2010. (TX, p. 62) Petitioner agreed that he had denied ever receiving a prior recommendation from a physician for surgery to address left knee problems, and that this answer did not mention the recommendation by Dr. Raab in 2010 for a left total knee replacement. (Id.) Petitioner agreed that he had not provided any answer on the form when asked to name previous treating physicians. (TX, p. 62-3)

Petitioner additionally agreed that he had answered "no" for every category in the space provided on the form asking about previous symptoms, including but not limited to the categories marked "musculoskeletal" (defined on the form as "joint, muscle, neck or back pain"), and that he had in fact previously experienced joint pain in his left knee. (TX, p. 63-4)

Regarding his return to Dr. Raab on March 19, 2014, Petitioner agreed that his complaint of left knee pain affecting his daily activities and quality of life was identical to the complaint he had previously voiced to Dr. Raab on September 23, 2010. (TX, p. 64-5) He agreed that the total knee replacement recommended by Dr. Raab on March 19, 2014 was the same surgery that he had discussed with Dr. Raab on September 23, 2010. (TX, p. 65)

He testified that he could not explain why he had stated that he had not previously had any surgeries on the health history form he had completed for Respondent on September 26, 2012 (see Pet. Ex. 1, p. 34-5), and that he assumed he had overlooked the question. (TX, p. 74) He admitted that he had certainly had "an operation or two." (TX, p. 74-5) His answer of "no" when asked on the form whether he had ever been advised to have an operation was based on a belief that Dr. Raab had not advised him he needed surgery in 2010. (TX, p. 75) He believed that his discussions in 2010 with Dr. Raab regarding total knee replacement were that he could have the surgery whenever he wanted it or whenever he felt he needed it. (Id.) His answer of "sprained ankle" and nothing else when asked on the form if he had had any medical attention in the previous five years was explained as not considering his visits with Dr. Raab to be medical attention. (TX, p. 75-6)

With regard to the medical history form he had completed on March 12, 2014 for Dr. Raab (see Pet. Ex. 2, p. 69-71), Petitioner confirmed the answers he had given reflecting a work injury. (TX, p. 77-79) He testified that his incorrect answers regarding previous tests or treatment to the left knee were given because he had been thinking only of the alleged March 10, 2014 injury, not of treatment or tests years prior. (TX, p. 79-80)

On recross examination regarding the September 26, 2012 medical history form, Petitioner agreed that the form reflected no indication of any prior left knee treatment in 2010 with Dr. Raab. (TX, p. 82) He agreed that there was a similar lack of any such indication on the March 12, 2014 medical history form. (TX, p. 81) He agreed that he had completed an additional medical history form on June 25, 2010 when seeing Dr. Raab. (TX, p. 83; see also Pet. Ex. 2, p. 72) He agreed that the nature of his pain complaints on both occasions were given as sharp, dull, throbbing, and aching. (TX, p. 84) He agreed that the severity of his pain complaints on both occasions were given as severe. (Id.) He agreed that the frequency of his pain complaints on both occasions were given as constant. (TX, p. 84-5) He agreed that the timing of his pain complaints on both occasions were given as during and after activity. (TX, p. 85) He agreed that he understood that at any point between 2010 and 2014 he could have chosen to undergo the left knee replacement surgery. (TX, p. 89)

RECORDS:

Prior to the March 10, 2014 alleged injury, the records in evidence reflect that Petitioner was first seen by a medical provider in regard to his left knee on April 17, 1996, when he was examined by Dr. Charles Bush-Joseph at Midwest Orthopaedics at Rush. (RX 2) Petitioner

complained of episodes of left knee instability occurring once or twice every month. He indicated that he had injured his left knee 12 years prior and had undergone arthroscopic surgery of an unknown nature. He had experienced another left knee injury six months later. He indicated that the recurring episodes of instability were associated with playing basketball, which he did avidly, but also had occurred while he was doing nothing more than walking down the street. On these occasions, knee effusion lasting from one to two weeks followed. He additionally reported some intermittent catching and clicking within the knee. Examination of the knee was unremarkable apart from a positive Lachman's test and a Grade 1 pivot shift. Dr. Bush-Joseph assessed Petitioner as having a left anterior cruciate ligament (ACL) tear, and recommended x-rays to assess the condition further.

Petitioner next returned to Dr. Bush-Joseph nearly two years later on February 11, 1998. (RX 2) Petitioner requested surgical reconstruction, and this was performed on March 12, 1998. The pre- and post-surgical diagnoses were 1) chronic left knee ACL insufficiency and 2) medical meniscal tear, left knee. During the surgery, arthritic changes were noted within several areas of the knee. He commenced physical therapy, and returned to Dr. Bush-Joseph several times for follow-up through May 7, 1999. He continued to voice complaints to Dr. Bush-Joseph of a loss of flexion in the left knee, and Dr. Bush-Joseph noted a reduction in flexion range when compared to the right knee. Dr. Bush-Joseph offered an option of additional arthroscopy and debridement without guarantee that this would help.

Petitioner next returned to Dr. Bush-Joseph on October 8, 1999 with complaints of swelling in the left knee following a "cutting and twisting injury" while playing basketball two weeks prior. Dr. Bush-Joseph felt that based upon his examination there may have been a rupture of the prior ACL graft or another meniscal tear, and recommended that he obtain an MRI for further assessment. Petitioner obtained the MRI, and Dr. Bush-Joseph's note of October 14, 1999 reflects that it showed a partial retear of the ACL. Petitioner did not follow up with Dr. Bush-Joseph thereafter.

The next record of treatment of the left knee is dated June 25, 2010, with Dr. David Raab of the Illinois Bone & Joint Institute. (PX 2) Petitioner completed a medical history questionnaire, indicating that he was experiencing left knee pain that was sharp, dull and throbbing, severe, constant, and noted with and after activity. Petitioner advised Dr. Raab of two prior left knee surgeries in 1988, including an ACL reconstruction, the subsequent ACL reconstruction performed by Dr. Bush-Joseph in 1998, and the re-tear of the ACL in 1999. He had not undergone further treatment, and was "ACL deficient" as of June 25, 2010. He had continued to play basketball and remained active, having lived with continuing left knee pain in the interim. He had recently seen a Dr. Rhode regarding left knee pain, and had undergone two months of physical therapy as well as a cortisone injection. This injection had not provided lasting relief.

X-rays confirmed "bone on bone" conditions in the medical compartment of the knee with additional degenerative changes in the lateral compartment and the patellofemoral joint. Dr. Raab arrived at diagnoses of degenerative arthritis in the left knee as well as ACL deficiency. He administered a Synvisc injection into the left knee, and prescribed Voltaren to Petitioner. He discussed the possibility of total knee replacement with Petitioner.

Petitioner then returned to Dr. Raab on September 3, 2010, having missed an appointment in the interim on July 23, 2010. On September 3, 2010, Petitioner advised that the Synvisc injection had provided one month of relief. He complained to Dr. Raab that he was "having difficulty walking and the pain is affecting his daily activities and quality of life." Dr. Raab had a "lengthy" discussion with Petitioner regarding total left knee replacement, including the details of the procedure, risks, complications, potentials for success and failure, the expected time to full recovery, and the rehabilitation period. Dr. Raab stated "This will be scheduled at his convenience pending medical clearance."

Petitioner did not return to Dr. Raab prior to 2014. In late 2012, Petitioner began working for Respondent Ford Motor Company. On September 26, 2012, he completed a "Health History" form at Respondent's request. (PX 1, p. 34-5) On this form, he indicated no significant prior medical history, checking "no" for questions regarding whether he had ever had bone or joint deformity, operations, arthritis, or a trick or locked knee. He indicated that he had never been hospitalized or advised to have an operation and had never been limited or restricted in working due to his health. He indicated that he had received medical attention within the previous five years, but only due to a sprained ankle at an unspecified time.

On March 10, 2014, Petitioner reported to Respondent that he had slipped on a piece of equipment used in building the "Taurus T-Bone". (PX 1, p. 5) He indicated that he had twisted his knee (though did not specify which knee). (Id.) He was seen at the on-site medical clinic, where he was assessed as having sustained a contusion of the left knee. (Id. at 20-1) He was noted to be ambulating with a limp but able to move his left knee freely. (Id. at 21) He was provided with Motrin and an Ace wrap, and he returned to work. (Id.) He returned to the clinic two hours later with continued complaints of pain that the medication had not reduced, and went home for the remainder of his shift. (Id. at 22-3)

Petitioner then saw Dr. Raab again on March 12, 2014. (PX 2, p. 26) He provided a history of slipping on a part while working, twisting his left knee inward. (Id.) He noted pain and swelling. (Id.) He noted intermittent pain in the left knee recently, without specifying as to the time frame of this pain. (Id.)

Petitioner completed a Medical History Form at the time of this visit with Dr. Raab. (PX 2, p. 69-71) On this form, he indicated a work injury to the left knee occurring on March 10, 2014. (Id. at 69) He characterized his left knee pain as sharp, moderate to severe, intermittent to constant, and during all types of activity. (Id.) He noted a previous history of problems with the

left knee, stating "Had an ACL tear 20 years ago", without reference to his visits to Dr. Raab and Dr. Rhode in 2010. (Id.) He stated that he had previously had no diagnostic tests for this problem. (Id.) He stated that a physician had not recommended that he have surgery for this problem. (Id.) He provided no answer when asked for the names of previous treating physicians. (Id.) He advised no history of musculoskeletal symptoms. (Id. at 70) He noted an ACL reconstruction by Dr. Bush-Joseph in approximately 1997. (Id. at 71) He signed the form where indicated, beneath text reading "To the best of my knowledge, the above information is accurate and complete." (Id.)

At the visit, Dr. Raab noted the history provided by Petitioner. (Id. at 26) He examined Petitioner's left knee and took x-rays. (Id. at 26-7) The x-rays revealed "bone on bone" conditions in the medial compartment with degenerative changes of the patellofemoral joint. (Id. at 27) Dr. Raab arrived at diagnoses of degenerative arthritis in the left knee as well as a post-reconstructed ACL. (Id.) Dr. Raab prescribed Voltaren, and indicated that Petitioner "would like to hold off on a cortisone injection at this time." (Id.) Dr. Raab restricted Petitioner to seated work only. (Id.)

Petitioner returned to Dr. Raab on March 19, 2014. (Id. at 24-5) The Voltaren had provided no relief. (Id.) He complained to Dr. Raab that "his knee is affecting his daily activities and his quality of life." (Id.) Dr. Raab discussed surgical versus nonsurgical options with Petitioner, including total knee replacement. (Id. at 25) He indicated that Petitioner "will schedule at his convenience pending Workers' Compensation clearance as well as medical clearance." (Id.)

Petitioner was seen again by Dr. Raab on April 9 and then on May 7, 2014, with no changes of significance relative to the note of March 19, 2014. (Id. at 21-2) He underwent the recommended total left knee replacement on July 31, 2014. (Id. at 19-20) He thereafter began physical therapy (see PX 3) and returned to Dr. Raab for several follow-up visits. On December 17, 2014, Dr. Raab released Petitioner to resume seated work only. (Id. at 15) This restriction was gradually relaxed through several more visits through July 8, 2015, at which time Dr. Raab released Petitioner to full-duty work without restrictions. (Id. at 10) On July 8, 2015, Dr. Raab found Petitioner to have reached a state of maximum medical improvement. (Id.) No work or activity restrictions of any kind were noted, and Petitioner was released from care to return only as needed. (Id.)

NARRATIVE REPORTS:

Petitioner submitted a narrative report by Dr. Raab into evidence, dated May 18, 2016. (PX 4) Dr. Raab stated that in 2010 he discussed total left knee replacement with Petitioner. (Id.) He noted the Petitioner's later return for treatment in 2014 as detailed above. (Id.) Dr. Raab opined that the alleged injury of March 10, 2014 was work-related and more likely than not was an aggravation of an "obviously" pre-existing degenerative knee. (Id.) While

acknowledging that he discussed total knee replacement with Petitioner in 2010, Dr. Raab opined that the "work related injury [seems] to have affected his baseline of this degenerative knee; and therefore, I do feel it is causally related" to the work injury. (Id.) Dr. Raab based this opinion on the belief that Petitioner had tolerated the knee after his visits in 2010 through March 10, 2014, was not able to return to work following that injury, and did thereafter undergo knee replacement.

Respondent submitted a narrative report by Dr. Preston Wolin into evidence, dated May 16, 2014. (RX 2) Dr. Wolin reviewed the 1998 and 1999 records of Dr. Bush-Joseph as well as the then-current records of Dr. Raab. (Id.) Dr. Wolin opined that the work episode of March 2014 did not aggravate or accelerate the pre-existing condition of medial compartment osteoarthritis in the left knee, based upon review of these records. (Id.) Dr. Wolin noted that a left total knee replacement was to be scheduled to occur in 2010, but the Petitioner apparently decided not to undergo that procedure. (Id.) As the need for the total knee replacement was already indicated in 2010, the 2014 episode therefore could not have been a factor in Petitioner's need for the procedure. (Id.)

CONCLUSIONS OF LAW

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

It is well established that a claimant carries the burden of proof with respect to each element of his claim by the preponderance of credible evidence. *Parro v. Indus. Comm'n*, 260 Ill.App.3d 551, 554-55 (1st Dist. 1993). The claimant may present witnesses to prove his case. It is the function of the Arbitrator to determine the credibility of those witnesses, draw reasonable inferences based on the testimony, and determine the weight to be assigned the testimony. *Parro*, 260 Ill.App.3d at 554. The Arbitrator need not find for a claimant merely because there is some testimony that standing alone would justify a favorable outcome. *Burrgess v. Industrial Comm'n*, 169 Ill.App.3d 670, 676 (1st Dist. 1988). Rather, the Arbitrator should consider both direct and circumstantial evidence and draw reasonable inferences there from, even if it is contrary to the testimony. (*Id.*) It is the Commission's function to evaluate the evidence and resolve the conflicts that arise. *Beattie v. Industrial Comm'n*, 276 Ill.App.3d 446, 449 (1995).

Credibility is the quality of a witness which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the witness' demeanor and any external inconsistencies with testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand.

McDonald v. Industrial Commission, 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission*, 52 Ill. 2d 490 (1972).

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

As it is a question of relevance to all findings on the disputed issues, the Arbitrator will first provide findings regarding the credibility of Petitioner's testimony at trial. In consideration of this question, the Arbitrator looks to the documentary evidence submitted by both parties. After carefully reviewing the record, weighing the evidence, and assessing Petitioner's credibil ity, the Arbitrator finds that the Petitioner was not a credible witness for several reasons.

It is abundantly clear from the medical records that Petitioner has a long history of left knee problems, as evidenced by records of medical treatment over multiple decades prior to the March 10, 2014 alleged injury. While some of the reporting is muddled, it is sufficiently documented to be certain at least that Petitioner underwent left knee arthroscopic surgery in the mid-to-late 1980s and an ACL reconstruction in 1998, and that he re-tore the ACL in 1999 but did not have it repaired again thereafter. Both Dr. Raab (for Petitioner) and Dr. Wolin (for Respondent) agreed that the Petitioner had pre-existing degenerative arthritis in his left knee as of the alleged injury on March 10, 2014. While there is a dispute between the parties as to whether total knee replacement to address this degenerative arthritis was "recommended" by Dr. Raab in 2010 or merely "discussed", there can be no question that Petitioner was a candidate for this procedure as of his visit with Dr. Raab on September 3, 2010.

The Arbitrator is notes the documentary evidence of selective omission of relevant facts on the part of Petitioner in his reporting to Dr. Raab in 2014 and to Respondent in 2012. As noted in the findings of fact, when Petitioner applied to become an employee of Respondent, he completed a "Health History" form (see PX 1, p. 34-5). Despite the undeniable fact that Petitioner had a well-documented history of significant left knee problems, and had in fact undergone multiple operations to the left knee by that point, Petitioner made no indication whatsoever on this form that he had ever experienced any medical problems other than a sprained ankle. He specifically denied any medical treatment in the previous five years other than for this condition, an assertion that was patently untrue, as he had seen Drs. Rhode and Raab two years prior, undergoing physical therapy and a Synvisc injection in addition to the discussion of total left knee replacement. Petitioner testified regarding this omission that "I just really

didn't think it was medical attention, I guess," which the Arbitrator finds not credible. (TX, p. 76)

Similarly, Petitioner specifically denied on this form having ever undergone an operation or even having been recommended by a physician to undergo an operation despite having undergone at least two previous left knee procedures at the recommendations of his physicians. Petitioner's answers in defense of these omissions were "I'm just assuming I overlooked that" and "because when I thought of my meeting with Dr. Raab, my understanding was that he didn't advise me I had to do surgery." (TX, p. 74-5) The Arbitrator does not find this explanation persuasive or credible.

The harm to Petitioner's credibility regarding this omission is deepened given that, when Petitioner returned to Dr. Raab on March 12, 2014 with complaints regarding his left knee, he once again failed to fully and accurately report his prior medical treatment. At this visit, Petitioner completed a Medical History questionnaire for Dr. Raab, as he had done in 2010, yet omitted any mention of having been to see Dr. Raab regarding his left knee in 2010. On the form, Petitioner did note a previous history of problems with the left knee, but stated only "Had an ACL tear 20 years ago." (PX 2, p. 69) Petitioner provided no explanation when testifying as to any rationale for this selective omission. He did provide an explanation on redirect examination for why immediately following this omission he had denied having any prior diagnostic tests for his left knee, testifying that his understanding of the question was that it was referring only to the days following his March 10, 2014 injury. (TX, p. 79) This explanation is not credible, given that his answer to the previous question on the form had specifically referred to treatment from 20 years prior, and thus directly contradicts his testimony.

Perhaps one could infer, absent evidence to the contrary, that Petitioner did not mention his 2010 treatment with Dr. Raab on the March 12, 2014 Medical History Form because Petitioner assumed Dr. Raab would remember him (although the Petitioner did not argue or advance such an inference when testifying). However, the actual note authored by Dr. Raab on March 12, 2014 conclusively rules out this theory. (See PX 2, p. 26-7) Dr. Raab's note makes no mention whatsoever of the 2010 visits and discussion or recommendation of a total knee replacement, and the history noted precisely mirrors that provided by Petitioner on the associated Medical History form. Dr. Raab's note refers exclusively to a past history of ACL repair in 1997 by Dr. Bush-Joseph, exactly the amount of information provided by Petitioner on his questionnaire and no more.

Additional evidence of Petitioner's lack of credibility in his testimony is found by comparing his complaints to Dr. Raab in 2010 and 2014. At trial, Petitioner testified that his decision to undergo total knee replacement following the March 10, 2014 incident was in contrast to his decision to forego the procedure after it was recommended in 2010 by saying: "I never felt pain like that. It would get sore and stuff, but not that type of pain." (TX, p. 26-7) However, the patient's descriptions of his pain symptoms on the forms he filled out for Dr. Raab

on June 25, 2010 and March 12, 2014 are nearly identical – and to the extent that there are minor differences, these minor differences indicate that his symptoms were reported as *more* severe in 2010. The June 25, 2010 form (PX 2, p. 74) claims pain symptoms that were:

- sharp,
- dull,
- throbbing,
- aching,
- severe,
- constant, and
- during and after activity.

with associated symptoms of:

- instability,
- visible swelling,
- weakness,
- stiffness,
- visual changes,
- locking, and
- giving way.

By comparison, the March 12, 2014 form (PX 2, p. 69) claims pain symptoms that were:

- sharp,
- moderate to severe,
- intermittent to constant, and
- during and after activity.

with no mention of associated symptoms, in contrast to the wide range of associated symptoms noted in 2010. Petitioner's testimony that his pain following the alleged March 10, 2014 injury was unprecedented in his personal experience cannot be reconciled with his statements on these two forms, and thus this testimony cannot be viewed as credible.

Based upon the totality of the evidence presented, the Arbitrator finds the Petitioner's testimony at trial to be less than fully credible, and places greater weight upon the documentary evidence in making findings as to the disputed issues below.

Regarding issues C) whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent and F) whether the Petitioner's current condition of ill-being is causally connected to the injury, the Arbitrator finds as follows:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Petitioner testified that there were no independent witnesses to the alleged incident of March 10, 2014 (TX, p. 56), and none are listed on the "Injury/Accident Investigation" form he completed subsequently (PX 1, p. 5). Analysis of the disputed issue of whether an accident occurred as alleged is thus largely dependent on Petitioner's credibility.

The Arbitrator notes that on the "Injury/Accident Investigation" form completed by Petitioner on March 10, 2014, he described the occurrence as taking place when he "slipped on a piece of equipment (used for Taurus T-Bone)." (Id.) This description is mirrored in the initial Ford medical clinic note of March 10, 2014 (PX 1, p. 20), as well as the note of Dr. Raab on the occasion of Petitioner's first post-incident visit (PX 2, p. 26). Petitioner additionally noted on the "Injury/Accident Investigation" form that the location of the injury was "By the Taurus stock." (PX 1, p. 5) These are the documents most closely following the alleged incident in temporal terms, and are thus viewed by the Arbitrator as the most reliable descriptions of this incident that are available, as they can be reasonably inferred to contain the Petitioner's most immediate recollection of the event.

This documented history varies somewhat from the version of events to which Petitioner testified at trial. With regard to the object upon which he slipped, Petitioner testified that it was "a small part that was about three inches wide and three inches in length, and it wasn't from my area." (TX, p. 15) However, the evidence does not establish whether a "part" is different than a "piece of equipment", and the Arbitrator does not view these terms as mutually exclusive. The evidence regarding the location of the alleged incident is likewise not determinative as to whether "by the Taurus stock" describes a location within Petitioner's work station (as Petitioner testified the incident took place within his assigned station; see TX, p. 16, 56) or elsewhere, and the Arbitrator does not view this discrepancy as inherently contradictory. While Petitioner bears the burden of proving the elements of his claim, the Arbitrator also notes that Respondent did not present any evidence to rebut Petitioner's claim that he slipped on an object on the floor while working on March 10, 2014.

While the Arbitrator has found the Petitioner to be less than fully credible in his testimony, the Arbitrator nevertheless finds that Petitioner has satisfied his burden of proof in showing that he sustained an accidental injury to his left knee on March 10, 2014 when he slipped on an object on the floor while working.

However, the Arbitrator finds that Petitioner has not sustained his burden of proof in showing that his subsequent condition of ill-being was causally related to that accidental injury.

This finding is based in significant part upon the Petitioner's lack of full credibility in his testimony, as documented above. As noted, Petitioner agrees that prior to the injury of March 10, 2014 he had a multi-decade-long history of ongoing left knee problems, but Petitioner alleged that these problems abated between September 3, 2010 and March 10, 2014. Given the Petitioner's lack of full credibility, the Arbitrator does not accept this assertion at face value, and looks to the medical evidence.

When comparing the medical records of Dr. Rabb's treatment of Petitioner in 2010 and 2014, there is no evidence that the Petitioner's "baseline" left knee condition was actually worsened. As documented previously, Petitioner's complaints were more severe in 2010 than they were in 2014. There is no statement in the March 2014 x-ray reports or in Dr. Raab's March 2014 treating records indicating any change in Petitioner's left knee condition in 2014 when compared to the x-rays and treating records from 2010. In fact, the Arbitrator notes that the reports in both cases use identical language when describing the "bone on bone" conditions within the knee that formed the basis for Dr. Raab's initial recommendation for a total knee replacement in 2010. Dr. Raab's records from both periods also contain identical complaints from the Petitioner that his left knee pain was "affecting his daily activities and quality of life" Furthermore, Dr. Raab's record of September 3, 2010 notes Petitioner's additional complaint that he was having difficulty walking, a complaint that was not reflected in the 2014 visit notes – serving as another indicator that the Petitioner's condition in 2010 was actually worse than his condition in 2014.

There is no evidence of any objective change in Petitioner's left knee condition following the March 10, 2014 incident relative to the condition of that knee as of September 3, 2010, or of any subjective increase in Petitioner's complaints at the later of the two periods of treatment. Petitioner was careful in his testimony to maintain that he and Dr. Raab merely "discussed" a left total knee replacement in 2010, and that such treatment was never "recommended" to him at that time. (See TX, p. 19-20, 50-51) For his part, Dr. Raab was also careful to draw this distinction in his narrative report of May 18, 2016. (PX 4) In this report, Dr. Raab states that the event of March 10, 2014 aggravated the pre-existing conditions within Petitioner's left knee, citing the Petitioner's apparent tolerance of those conditions between 2010 and 2014 as his sole basis for opining that the March 10, 2014 event "seems to have affected his baseline of this degenerative knee; and therefore, I do feel it is causally related." (Id.)

The Arbitrator finds that in the circumstances presented there is no meaningful difference between Petitioner's position that the left total knee replacement was "discussed" in 2010 and the Respondent's position that it was "recommended" at that time. On September 3, 2010, Dr. Raab's record reflects that Petitioner had not experienced sustained relief from previously-administered conservative treatments and that:

> "Dr. Raab had a lengthy discussion with the patient regarding left total knee arthroplasty. He has discussed the details of the procedure, risks, complications,

potentials for success, failure, expected time to full recovery and the rehabilitation period. This will be scheduled at his convenience pending medical clearance." (PX 2, p. 40)

No other treatment options were presented to Petitioner, and the language quoted shows that the discussion did not involve any alternatives to the arthroplasty. The Arbitrator finds that the only reasonable inference based on this record is that Dr. Raab recommended the left total knee arthroplasty to Petitioner on September 3, 2010. This inference is reinforced by the fact that Dr. Raab used nearly identical "discussed" language in his note of March 19, 2014:

> "On today's visit Dr. Raab did discuss the risks and benefits, success and failure, time for full recovery of a left total knee arthroplasty. He will schedule at his convenience pending Workers' Compensation clearance as well as medical clearance." (PX 2, p. 25)

Dr. Wolin's opinion as submitted by the Respondent is succinct:

> "On the basis of the records reviewed, it is clear that the subject had established medial compartment arthritis prior to the [March 10, 2014] episode. It is also clear that the subject was a candidate total joint arthroplasty as early as 2010 having failed nonoperative treatment. In fact it was to be scheduled to occur in 2010. Apparently the subject decided not to undergo that procedure. However, since the arthroplasty was already indicated, the 2014 episode could not have been a factor in the need for knee arthroplasty." (RX 1)(sic)

The Arbitrator adopts the opinion of Dr. Wolin and assigns this opinion greater weight than that of Dr. Raab. There is simply no evidence that the Petitioner's pre-existing left knee condition was aggravated in any way by the incident of March 10, 2014, and thus no evidence that this incident accelerated his need for a surgery that he had already needed since 2010.

The most crucial fact in this analysis is that on March 19, 2014, Dr. Raab recommended the same surgical procedure for Petitioner that he had recommended on September 3, 2010. On both occasions there was no alternative treatment suggested or recommended, and on both occasions Dr. Raab indicated that Petitioner would schedule the procedure at his convenience. On both occasions Dr. Raab only "discussed" this procedure with Petitioner. Petitioner claims his understanding in 2010 was that the procedure was not recommended but in 2014 it was, despite the near-identical language used by Dr. Raab on these occasions.

Taking into account the totality of the evidence, including the Petitioner's testimony, the Petitioner's lack of full credibility in his testimony, the medical findings, the opinions provided by Drs. Raab and Wolin, and the evidence of Petitioner's apparent efforts to hide the existence of

his prior need for left total knee replacement from Respondent and from his own doctor as evidenced in the medical history reports he completed on September 26, 2012 and March 12, 2014, the Arbitrator finds that Petitioner's left knee condition of ill-being as of March 19, 2014 and thereafter was not causally connected to the injury of March 10, 2014.

Regarding issue J) whether the medical treatment provided to Petitioner was reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator incorporates the findings previously made regarding Petitioner's credibility and regarding issues C) and F) as noted above.

Having found that Petitioner's condition of ill-being as of March 19, 2014 and thereafter was not causally connected to the injury of March 10, 2014, the Arbitrator denies all medical treatment and medical bills for such treatment after March 19, 2014, as also not causally connected to the injury of March 10, 2014. The Arbitrator therefore awards medical benefits only for Petitioner's office visits to Dr. Raab on March 12 and 19, 2014, as well as the x-rays taken on March 12, 2014.

According to Petitioner's Exhibit 2, the charges for these visits and x-rays total $327.00, and these charges shall be paid by Respondent pursuant to the Medical Fee Schedule. The billing statements reflect that these charges were paid by group insurance with payments totaling $225.29. As agreed by the parties, to the extent that these charges were paid by Petitioner's group insurance through his employment with Respondent, the Respondent is awarded equal credit pursuant to Section 8(j) of the Act, and shall hold Petitioner harmless for any claim by the insurer for reimbursement of same.

Regarding issue K) whether Petitioner is entitled to temporary total disability benefits, the Arbitrator finds as follows:

The Arbitrator incorporates the findings previously made regarding Petitioner's credibility and regarding issues C), F), and J) as noted above.

Having found that Petitioner's condition of ill-being as of March 19, 2014 and thereafter was not causally connected to the injury of March 10, 2014, the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits for lost time subsequent to March 19, 2014. As no lost time was claimed by Petitioner between March 10, 2014 and March 19, 2014, the Arbitrator denies all temporary total disability benefits claimed.

Regarding issue L), the nature and extent of Petitioner's injury, the Arbitrator finds as follows:

The Arbitrator incorporates the findings previously made regarding Petitioner's credibility and regarding issues C), F), J) and K) as noted above.

Pursuant to Section 8.1b of the Workers' Compensation Act, the Arbitrator includes five factors in determining the extent of permanent partial disability sustained by the Petitioner as the result of the injury of March 10, 2014. The Arbitrator gives these factors weight as follows:

i. The reported level of impairment pursuant to subsection (a) (AMA Impairment Rating) – neither party presented an impairment rating, and thus this factor is assigned no weight.

ii. The occupation of the injured employee – Petitioner testified that his duties for Respondent involved lifting large but light parts into a robotic welder for assembly, and then removing the combined piece for further assembly. Petitioner testified that the combined and completed piece weighed approximately 20 pounds. Petitioner testified that prior and subsequent to this employment he worked as a trader or in software sales, and there is no evidence that this employment involved any degree of heavier work. Petitioner testified that he is between jobs at present. While Petitioner claimed that Dr. Raab restricted him from running, there is no documentary evidence of any such restriction and the Arbitrator does not find this allegation credible. The Arbitrator assigns minimal weight to this factor, as there is no evidence that Petitioner is restricted in any ability to perform any occupational tasks, and was in fact released by Dr. Raab to full-duty work without any restrictions on July 8, 2015.

iii. The age of the employee at the time of injury – Petitioner was 51 years old at the time of injury, and there is no indication in the records that his age played a role in his injury or recovery. The Arbitrator assigns minimal weight to this factor.

iv. The employee's future earning capacity – no evidence was introduced suggesting that Petitioner has sustained any diminishment to his future earning capacity as a result of this injury. The Arbitrator assigns no weight to this factor.

v. Evidence of disability corroborated by the treating medical records – Having found that Petitioner's condition of ill-being after March 19, 2014 was not causally connected to the work injury of March 10, 2014, any disability to Petitioner resulting from the subsequent left total knee replacement is not considered by the Arbitrator in this analysis. The medical records immediately following the March 10, 2014 injury do not show any worsening of Petitioner's pre-existing conditions, and Petitioner testified that his alleged increase in pain on

March 10, 2014 subsided at an unspecified later time (TX, p. 33). Dr. Raab's diagnosis following the March 10, 2014 injury was pre-existing degenerative arthritis, and there is no evidence that this condition was worsened by the injury. The Arbitrator assigns this factor some weight.

After taking all of the above factors into account, the Arbitrator finds that as a result of the work-related injury of March 10, 2014, Petitioner sustained permanent partial disability equal to 1% loss of use of the left leg.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8(e) of the Act. Respondent shall pay Petitioner permanent partial disability benefits**$384.53**/week for **2.15** weeks, because the injuries sustained caused the 1% loss of the left leg, as provided in Section 8(e) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $327.00 to Illinois Bone & Joint Institute for dates of service 3/12/14 and 3/19/14 as provided in Sections 8(a) and 8.2 of the Act.

Because the Petitioner's condition of ill-being following the injury of 3/10/14 was not causally connected to said injury after 3/19/14, further benefits are denied.

Deberah L. Simpson

Signature of Arbitrator

February 1, 2017
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GENA CARPENTIER,

Petitioner,

vs. NO: 14 WC 28956

KROGER,

Respondent.

18IWCC0162

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 7, 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.

18IWCC0162

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

DATED: MAR 19 2018
KWL/bsd
O: 01/23/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARPENTIER, GENA
Employee/Petitioner

Case# **14WC028956**

KROGER
Employer/Respondent

18IWCC0162

On 6/7/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

1739 STONE & JOHNSON
J MURRAY PINKTON III
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Gena Carpentier
Employee/Petitioner

v.

Kroger
Employer/Respondent

Case # 14 WC 28956

Consolidated cases: n/a

18IWCC0162

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

DISPUTED ISSUES

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

FINDINGS

On June 21, 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 $21,669.96; the average weekly wage was $416.73.

On the date of accident, Petitioner was 47 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $277.82 per week 56 3/7 weeks, commencing July 30, 2014, through August 31, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $253.00 per week for 100 weeks because the injury sustained caused the 20% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

June 5, 2017
Date

JUN 7 - 2017

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on June 21, 2014. According to the Application, Petitioner was "Pulling pallet out of dairy cooler and felt pain" and sustained an injury to "Upper back, neck, and left arm" (Petitioner's Exhibit 1). Petitioner and Respondent stipulated that Petitioner sustained a work-related injury; however, Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner testified she had worked for Respondent for approximately 20 years. In June, 2014, Petitioner was the Lead Nutrition Clerk. Petitioner's job duties consisted primarily of stocking shelves. On June 21, 2014, a delivery of food had just been made. The food was on a pallet and, when Petitioner pulled on it, she experienced an onset of pain in her left shoulder blade and the mid portion of her back.

Petitioner stated that she had just had rotator cuff surgery performed on the left shoulder approximately five to six months prior to June 21, 2014. Initially, Petitioner thought she had aggravated that condition.

Petitioner deferred seeking any medical treatment until July 2, 2014, when she was seen by Dr. Steven Below, the orthopedic surgeon who performed the left shoulder surgery. Dr. Below opined Petitioner had left shoulder pain following moving some pallets at work. He opined that Petitioner had not sustained a new rotator cuff tear, but that Petitioner may have irritated her shoulder (Respondent's Exhibit 5).

On July 9, 2014, Petitioner was seen by Dr. Kenneth Frasier. At that time, Petitioner complained of left shoulder and scapular pain as well as pain in the left side of the neck. Dr. Frasier ordered x-rays of the cervical spine which revealed a reversal of cervical lordosis at C3-C4 and disc space narrowing at C4-C5 and C5-C6. Dr. Frasier's record noted that Petitioner had previously had an MRI of the cervical spine performed on June 15, 2010 (Petitioner's Exhibit 2).

Petitioner was previously seen by Dr. William Stevens for chronic neck and right shoulder pain on June 15, 2010. The MRI that was performed that same day revealed right foraminal encroachment at C2-C3 and C3-C4 and a leftward annular bulge at C6-C7. The record noted that Petitioner had chronic right shoulder pain for 13 years and a history of multiple right shoulder surgeries (Respondent's Exhibit 8).

On July 9, 2014, Petitioner was also seen by Dr. Barry Miller. When seen by Dr. Miller, Petitioner informed him of her prior left shoulder surgery and the accident of June 21, 2014. In describing the accident, Petitioner stated she was pulling a pallet of produce and "...felt something go in her neck and trapezius muscle and has had discomfort ever since." (Respondent's Exhibit 8).

On July 14, 2014, Petitioner was seen by Dr. Mary Stapel, her family physician. At that time, Petitioner informed Dr. Stapel that she initially had pain in the thoracic area of the back, but subsequently had neck pain. Petitioner provided a history to Dr. Stapel of pulling a pallet that,

unknown her at the time, was "wedged" and she thought she had pulled a muscle. Dr. Stapel opined Petitioner had a muscular strain and recommended physical therapy (Petitioner's Exhibit 3).

Petitioner was subsequently seen by Dr. Stapel on July 30, 2014. At that time, Petitioner had symptoms of numbness/tingling in the left arm, but denied having neck pain which was present at the time of her prior examination. Dr. Stapel opined Petitioner may have had subscapular nerve entrapment caused by the injury and recommended continued physical therapy (Petitioner's Exhibit 3).

Petitioner was again seen by Dr. Stapel on August 11, 2014, and Petitioner advised that her symptoms had worsened. Dr. Stapel ordered an MRI scan of the cervical spine which was performed on August 16, 2014. The MRI revealed a moderate size left foraminal disc protrusion at C6-C7 impinging the left C7 nerve (Petitioner's Exhibits 2 and 3).

Dr. Stapel evaluated Petitioner on August 25, 2014, and reviewed the MRI. She opined the MRI revealed a disc herniation at C6-C7 with impingement of the nerve. She subsequently referred Petitioner to Dr. Jeffrey Klopfenstein, a neurosurgeon.

Dr. Klopfenstein initially saw Petitioner on September 9, 2014. At that time, Petitioner advised that she developed left intrascapular pain with radiation down the left arm into the first and second digits. Dr. Klopfenstein reviewed the MRI and opined it revealed a left paracentral C6-C7 disc protrusion versus herniation resulting in C7 foraminal stenosis to the left. Dr. Klopfenstein recommended Petitioner undergo a surgical procedure which would consist of C6-C7 discectomy, fusion and plating (Petitioner's Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. Lawrence Li, an orthopedic surgeon, on February 10, 2015. In connection with his examination of Petitioner, Dr. Li reviewed medical records provided to him by Respondent. Dr. Li opined that Petitioner's complaints of upper thoracic/scapular pain were related to the accident of June 21, 2014. However, in regard to the C6-C7 disc protrusion and its impingement on the C7 root, Dr. Li opined that this was not related to the accident of June 21, 2014, primarily because the symptoms did not appear until approximately one month to one and one-half months after the accident (Respondent's Exhibit 2).

Dr. Klopfenstein performed surgery on May 11, 2015. The surgical procedure consisted of a C6-C7 anterior cervical discectomy, bilateral decompressive foraminotomies and a C6-C7 fusion with grafting and plating (Petitioner's Exhibit 9).

Following surgery, Petitioner was seen by both Dr. Klopfenstein and Dr. Stapel and received physical therapy. Petitioner was released return to work without restrictions on September 1, 2015 (Petitioner's Exhibits 3 and 4).

At the direction of her counsel, Petitioner was examined by Dr. Patrick O'Leary, an orthopedic surgeon, on December 10, 2015. In connection with his examination of Petitioner, Dr. O'Leary reviewed medical records and the report of Dr. Li which were provided to him by Petitioner's

counsel. In regard to causality, Dr. O'Leary opined that Petitioner's pulling the pallet caused Petitioner's neck to be strained and the disc to rupture. He noted that the presence of posterior scapular pain coming from the shoulder can actually be indicative of C7 radiculopathy. He noted that the records of both Dr. Klopfenstein and Dr. Stapel, the mechanism of how Petitioner sustained the injury and his findings on examination supported that opinion (Petitioner's Exhibit 8; Deposition Exhibit 2).

Dr. O'Leary also stated he disagreed with Dr. Li's opinion in regard to causality. Dr. O'Leary noted that it was not unusual for someone to initially complain of shoulder/scapular symptoms and for problem to actually come from the cervical spine, specifically, the C7 nerve root (Petitioner's Exhibit 8; Deposition Exhibit 2).

Dr. Li was deposed on January 21, 2016, and his deposition testimony was received into evidence at trial. Dr. Li's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Specifically, Dr. Li stated Petitioner had two separate issues, pain in the upper thoracic scapular area that sometimes radiated into the neck and numbness/tingling going down the left arm consistent with compression of the C7 nerve root caused by a C6-C7 disc protrusion. He testified the accident caused the upper thoracic and shoulder pain, but not the numbness/tingling associated with the C6-C7 disc protrusion. Dr. Li's primary explanation for his opinion as to the disc protrusion not being related to the accident was that the symptoms associated with that condition did not occur until approximately four to six weeks post accident (Respondent's Exhibit 1; pp 14-16).

On cross-examination, Dr. Li reaffirmed his opinion that the C6-C7 disc protrusion was not related to the accident. When asked what it was caused by, Dr. Li stated it was either idiopathic or related to degenerative changes caused by someone being middle aged (Respondent's Exhibit 1; p 24).

Dr. O'Leary was deposed on May 24, 2016, and his deposition testimony was received into evidence at trial. Dr. O'Leary's testimony was consistent with his medical report and he reaffirmed the opinions contained therein, in particular, that Petitioner's C6-C7 disc herniation was related to the accident of June 21, 2014. Dr. O'Leary explained the basis for his opinion in considerable detail. He noted that, in his practice, it was not unusual for him to see a patient two or three months after an injury when they had a constellation of symptoms which were later found to all be related. He also stated that he had performed C6-C7 fusions on patients with the same complaints Petitioner had without any pain radiating into the left arm (Petitioner's Exhibit 8; pp 16-18).

Dr. Li again saw Petitioner on February 24, 2017. In his report of that date, he reaffirmed his opinion that the C6-C7 disc protrusion was not related to the accident of June 21, 2014. He also opined that Petitioner had an impairment rating of five percent (5%) of the whole person based upon the AMA Guides (Respondent's Exhibit 3).

At trial, Petitioner testified that, following surgery, the pain symptoms had resolved. Petitioner stated that she still experiences some stiffness in the neck. Petitioner agreed she was able to return to work to the same job that she had at the time she sustained the accident and was continuing to work for Respondent in that same capacity.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of June 21, 2014.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related accident on June 21, 2014, when Petitioner pulled on a pallet.

Petitioner's complaints were initially to her left shoulder and mid portion of her back; however, Petitioner subsequently developed neck pain and left arm numbness/tingling.

Petitioner had recently undergone left rotator cuff surgery and, at first, thought that she had aggravated that condition.

Petitioner previously had an MRI of the cervical spine performed on June 15, 2010, which revealed a leftward annular bulge at C6-C7, but no disc protrusion/herniation.

Prior to June 21, 2014, no cervical disc surgery was either recommended or performed.

The MRI performed on August 16, 2014, revealed a moderate size left foraminal disc protrusion at C6-C7 impinging the left C7 nerve root. Obviously, there was disc pathology noted in the 2014 MRI that was not noted in the 2010 MRI.

The basis for Respondent's disputing medical causality was the opinion of Dr. Li that the disc protrusion at C6-C7 was not related to the accident of June 21, 2014.

The primary basis for Dr. Li's opinion in regard to causality was that Petitioner did not exhibit symptoms consistent with a C7 impingement until one to one and one-half months after the accident.

Dr. O'Leary opined that a delay of two to three months for a patient to develop various symptoms was not unusual. Further, he stated he had performed C6-C7 fusions on patients with the same complaints Petitioner had.

When asked to explain how Petitioner sustained the C6-C7 disc protrusion, Dr. Li stated it was either idiopathic or Petitioner being middle aged, but provided no other explanation.

Based upon the preceding, the Arbitrator finds the opinion of Dr. O'Leary in regard to causality to be more persuasive than that of Dr. Li.

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

The Arbitrator concludes that all the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical services incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 56 3/7 weeks, commencing July 30, 2014, through August 31, 2015.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner was temporarily totally disabled during the aforestated period of time.

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 20% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Dr. Li opined Petitioner had an impairment rating of five percent (5%) of the whole person based upon the AMA Guides. The Arbitrator gives this factor moderate weight.

Petitioner was a Lead Nutrition Clerk and her job required to stock shelves. This job required moving/lifting of stock. The Arbitrator gives this factor moderate weight.

Petitioner was 47 years old at the time of the accident. Petitioner will have to live with the effects of this injury for the remainder of her working and natural life. The Arbitrator gives this factor moderate weight.

There was no evidence that this injury had any effect on Petitioner's earning capacity. The Arbitrator gives this factor no weight.

Petitioner was diagnosed with a herniated disc at C6-C7 which required surgery. The surgical procedure consisted of a discectomy, bilateral foraminotomies and a fusion with metal hardware. Petitioner's upper extremity symptoms resolved; however, Petitioner still has complaints of neck stiffness. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

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

Janet Sanders,
Petitioner,

18IWCC0163

vs.

NO: 11 WC 37738

State of IL Secretary of State,
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, permanent disability, temporary disability, wage, rate and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 4, 2016, is hereby affirmed and adopted.

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

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

DATED: MAR 19 2018
o3/8/18
DLS/rm
046

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

18IWCC0163

SANDERS, JANET
Employee/Petitioner

Case# **11WC037738**

ST OF IL SECTETARY OF STATE
Employer/Respondent

On 10/4/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0144 CRAIN MILLER & WERNSMAN LTD
BRIAN C WERNSMAN
623 E BROADWAY PO BOX B67
CENTRALIA, IL 62801

0499 DEPT OF CENTRAL MGMNT SERVICE
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
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SWANSEA, IL 62226

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
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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 4 2016

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

18IWCC0163

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Janet Sanders
Employee/Petitioner

v.

State of Illinois Secretary of State
Employer/Respondent

Case # **11** WC **37738**

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 **Mt. Vernon**, on **July 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 16, 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 these dates, 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, per the stipulation of the parties, Petitioner earned **$36,531.38** and the average weekly wage was that of **$702.53**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$14,653.41** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$14,653.41**.

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$468.35/week** for **31 1/7** weeks, **for the timeframes of November 16, 2010 through March 2, 2011 and August 12, 2014 through December 1, 2014,** as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$14,653.41** for TTD, **$0** for TPD, $0 for maintenance, and **$0** for other benefits, for a total credit of **$14,653.41**.

Respondent shall pay Petitioner the sum of **$421.52/week** for a further period of **150 weeks**, as provided in Section 8(d)2 of the Act, because the injuries sustained caused **30% 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.

Melinda M. Pope-Sullivan

Signature of Arbitrator

9/29/16

Date

ICArbDec p. 2

OCT 4 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Janet Sanders
Employee/Petitioner

Case # **11** WC **37738**

v.

Consolidated cases: **N/A**

State of Illinois Secretary of State
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she started working for the Respondent as a Public Service Representative in 2000, and that her work location is in Centralia. Petitioner testified that the photo marked as Petitioner's Exhibit 1 showed the north side of the Driver's Services building, which is where the customers park. She testified that the north side contains signage identifying the building as a Driver's Services office and that the north side is where the customer's entrance is located.

Petitioner testified that the photo marked as Petitioner's Exhibit 2 showed the south side of the Driver's Services building, including a parking area which is where she was instructed to park by her supervisors. She testified that the photos marked as Petitioner's Exhibits 3 and 4 showed the south wall of the Driver's Services building, including a door which she identified as the employee's entrance. She testified that if a customer happened to use that door, she was instructed to inform them that they are not allowed to use that door and that it is for employees only. She testified that generally if a customer parked in the south parking area, they do not use the door that says "Do Not Enter" but rather walk around the building to the front/north side.

Petitioner testified that the photos also showed a mat at the entrance to the employee door, which was not present when she fell on December 16, 2008. She testified that the photos showed new concrete repairs that were not present on December 16, 2008, and that the repairs were made to correct the area where the concrete was messed up and where the water stood in 2008 when she fell. She testified that that although there is an overhang over the door, it did not keep water off the ground in that area.

Petitioner testified that her work day begins at 8:00 a.m. She testified that on December 16, 2008, she arrived at work at 7:55 a.m. and parked on the south side of the building as she was instructed to do by her supervisor. She testified that she exited her vehicle and entered the workplace through the employee door on the south side of the building. She testified that she set her purse down and realized that she did not have her badge, and that employees were required to have their name badges on at work. She testified that she recalled signing in before she went to retrieve her badge. Her co-worker, Ann Ashby, however, testified that Petitioner did not sign in.

Petitioner testified that as she went to retrieve her employee badge from her vehicle, she took two steps out the back door when she slipped on a small patch of ice on the pavement. Both Petitioner and Ann Ashby testified that the doors were opened for the customers at exactly 8:00 a.m. Petitioner testified that she slipped on a small patch of ice that had formed in a depressed area of the concrete outside the employee door. She testified that there was always water standing there. Ms. Ashby also testified that

there was an area right outside the door that seemed to accumulate water more than the rest of the parking area and that the condition had been there for several years. In her Worker's Compensation Witness Statement dated December 17, 2008, Ms. Ashby identified the accident has having occurred "outside the employee door". (RX3). Furthermore, the Supervisor's Report of Injury stated in response to the inquiry of "*Describe any unsafe acts or conditions which contribute to the accident/incident:*" that "BAD WEATHER-LOT NOT CLEANED. PATCH OF ICE AT BACK DOOR" (RX1).

Petitioner testified that when she fell, she landed on her left knee and her right leg went straight out and she landed on both of her hands, and her neck snapped back. She testified that Ms. Ashby helped her get up off of the ground. She testified that she then went back inside the office and reported the accident to her supervisor, Mary Jane Timmerman.

Petitioner and Ms. Ashby both testified that she and other Secretary of State employees cleaned or placed salt on the area just outside the employee door on previous occasions. The Supervisor's Report of Injury indicated that Ann Ashby went to the store to buy salt to correct the unsafe condition related to Petitioner's fall. (RX1). Ms. Ashby testified that that the employees cleaned and scraped more before than they had lately, as the landlord had now hired someone that came and cleaned the lot.

The photograph depicting the north side of the facility was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The photograph depicting the south side of the facility was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Photographs depicting the south door of the entrance to the facility were entered into evidence at the time of arbitration as Petitioner's Exhibits 3 and 4. The photograph depicting the view out the south door of the facility was entered into evidence at the time of arbitration as Petitioner's Exhibit 5.

The medical records and bills of Williams Chiropractic were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner was initially seen on December 19, 2008 at which time she reported that she was walking out the back door of work when she slipped and fell on ice, landed on her left knee and left hand with her right leg straight out to the side. The records reflect that Petitioner treated during the timeframe of December 19, 2008 through March 3, 2009, at which time it was noted that Petitioner stated that she had been feeling fairly good, that she felt some soreness in her neck and back but she was able to deal with it fairly well. (PX6).

The medical records and bills of Salem Township Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Petitioner underwent x-rays of the lumbar spine on December 19, 2008 for a clinical history of low back pain and were interpreted as revealing (1) very minimal osteoarthritis of the lumbar spine; (2) no recent fracture, dislocation, bone erosion or bone destruction is noted; (3) no evidence of spondylosis or spondylolisthesis is seen; (4) the intervertebral spaces, pedicle and soft tissue are unremarkable. The records reflect that x-rays of the cervical spine were performed on the same date for a clinical history of cervical spine strain and were interpreted as revealing (1) there is moderate osteophyte formation at the margin of the body of the C4, C5 and C6 noted with a degenerative change of the intervertebral disks of C4-C5 and C5-C6; (2) no recent fracture or dislocation is seen; (3) the remainder of the intervertebral spaces and pedicles are unremarkable; (4) minimal extension of the osteophyte into the cervical foramina of the C4-C5 and C5-C6 is noted; (5) the prevertebral soft tissues are unremarkable. (PX7).

The medical records of Dr. James Schutzenhofer were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Petitioner was seen on April 8, 2009 with complaints related to a cough, chest congestion, sore throat and headaches. It was noted that Petitioner fell on December 16, 2008 and that she had right-sided posterior neck pain and had not improved with chiropractic treatment. (PX8).

The medical records of Orthopaedic Center of Southern Illinois (5/1/09-9/22/14) were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. At the time of the August 20, 2014 visit, it was noted that Petitioner was a little over a week out from a fusion at C5-C6 and that she had a delayed nonunion at that level. At the time of the August 1, 2014 visit, it was noted that Petitioner had a nonunion at C5-C6 and had a complete fusion at C6-C7, so Dr. Kovalsky planned to take the plate out and re-fuse C5-C6 using an iliac crest autograft. At the time of the April 16, 2014 visit, it was noted that Petitioner had a work-related cervical disc herniation at C5/6 and C6/7 and that she underwent a cervical discectomy and fusion at both levels in November of 2010. It was noted that Petitioner developed a fibrous nonunion at C5/6, and that over the last 6 months the pain had increased. At the time of the January 15, 2014 visit, it was noted that Petitioner was still having some neck pain and headaches without radicular arm or shoulder pain, and that she had been contemplating surgical intervention for the last 6 months. It was noted that Petitioner used a bone grown stimulator for over 6 months but it did not result in healing, and that Petitioner could not decide whether she wanted to have surgery or not. (PX9).

The records of Orthopaedic Center of Southern Illinois reflect that at the time of the October 3, 2013 visit, Petitioner was characterized as having a nonunion at C6/7 and solid fusion at C5/6. It was noted that Petitioner had anterior cervical discectomy and fusion C5/6 and C6/7 over two years ago and was diagnosed to have a delayed union at C6/7. At the time of the October 3, 2012 visit, it was noted that Petitioner probably had a partial bony union. It was noted that since Petitioner was doing well clinically and radiographically, the bone growth stimulator would be discontinued. At the time of the June 7, 2012 visit, it was noted that Petitioner was still having some mild residual neck pain with no radicular arm pain. It was noted that Petitioner was diagnosed to have delayed union at C6/7 based on x-rays, and that she was using an external bone grown stimulator. It was noted that Petitioner was not sure whether or not she would consider having a revision discectomy and fusion if it ultimately did not heal. At the time of the March 7, 2012 visit, it was noted that Petitioner was having some posterior neck pain without any radicular shoulder or arm pain and that her symptoms were significantly improved versus her pre-operative status, although she still had some nuisance discomfort. Petitioner was recommended to continue using the bone growth stimulator for at least an additional three months. (PX9).

The records of Orthopaedic Center of Southern Illinois reflect that at the time of the December 2, 2011 visit, Petitioner stated that her symptoms other than some posterior neck pain were completely resolved. It was noted that the CT showed a nonunion at C5/6. Petitioner was recommended to be fitted for an external bone growth stimulator. At the time of the June 15, 2011 visit, it was noted that Petitioner continued to do extremely well, that she was not having any radicular pain in her arms but that she had some stiffness and a little bit of tingling on the left side of her neck (improved). At the time of the March 2, 2011 visit, it was noted that Petitioner stated that she was feeling much better. It was noted that Petitioner was to be released back to full duty work as of the next day. At the time of the January 12, 2011 visit, it was noted that Petitioner stated that she had been doing much better but that she still had a little bit of tenderness as well as some tingling right at the base of the neck and heading out towards both shoulders which she though was more of a muscular pain. At the time of the November 24, 2010 visit, it was noted that Petitioner stated that her arm pain had greatly improved since before surgery. At the time of the November 10, 2010 visit, Petitioner underwent pre-surgical evaluation. It was noted that Petitioner continued to have pain in her neck, which was starting to go down into her left shoulder. (PX9).

The records of Orthopaedic Center of Southern Illinois reflect that Petitioner was seen on September 30, 2010, at which time it was noted that she slipped and fell at work approximately two years ago and had progressive worsening of neck pain, cephalgia and headaches with only minimal radicular symptoms on the right side. It was noted that Petitioner had failed conservative treatment, and that the repeat MRI showed degenerative changes at C4-5 and C5-6, as well as an old calcified central disk herniation at C5-6 degenerative disc disease with spondylosis at C4-5. Surgical intervention was discussed, and it was noted that Petitioner was not a candidate for cervical disc replacement because she

had relatively longstanding cervical spondylosis with facet degenerative changes and that she was a better candidate for anterior cervical disckectomy and fusion. At the time of the August 13, 2010 visit, it was noted that Petitioner was seen for axial neck pain with MRI evidence of cervical degenerative disc disease at C4-5, C5-6 which only had partial improvement after a series of three epidural injections. It was noted that Petitioner was referred to Dr. Kovalsky. At the time of the January 25, 2010 visit, it was noted that Dr. Smith last saw Petitioner on November 13, 2009 for her neck pain and upper shoulder pain, and that she had a series of two right C3-6 diagnostic medial branch blocks which were all positive. It was noted that Petitioner received a right C3-6 medial branch rhizotomy in October, but she felt there was only 30% improvement after the procedure. At the time of the May 1, 2009 visit, it was noted that Petitioner reported a 5-month history of pain in the back of the neck after falling forward on the ice, landing on her knees and noticing a whiplash motion of the neck. The impression was that of (1) axial neck pain, probably due to whiplash injury which is suggestive of possible cervical facet syndrome; (2) radiographic evidence of cervical degenerative disc disease at C4-5, C5-6; (3) other medical co-morbidities. (PX9).

Included within the records of Orthopaedic Center of Southern Illinois was an interpretive report for an MRI of the cervical spine performed on May 21, 2009, which was interpreted as revealing (1) At C5-6, minimal central canal stenosis due to a posterior disc osteophyte complex; no cord deformity; moderate narrowing of the right neural foramen with possible encroachment on the right C6 dorsal root ganglion; (2) at C4-5, mild broad based posterior disc osteophyte complex with contouring of the cord; no cord deformity; moderate bilateral neural foraminal narrowing with possible encroachment of the C5 dorsal root ganglia; (3) straightening of the cervical lordosis. (PX9).

The medical records of Orthopaedic Center of Southern Illinois (9/22/14-12/2/15) were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. At the time of the December 2, 2015 visit, it was noted that Petitioner had mild neck pain, no headaches and no radicular arm pain. The clinical impression was that of resolved neck pain and arm pain status post cervical discectomy and fusion at C4/5 and C5/6, with some minor residual neck spasm and low back pain. Petitioner was placed at maximum medical improvement and it was noted that she did not require ongoing care other than medication management. (PX10).

The medical records of St. Mary's Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. Petitioner underwent a physical therapy evaluation on October 28, 2009 for a primary diagnosis of neck pain. It was noted that Petitioner reported an onset/exacerbation of her neck symptoms on December 16, 2008 when she fell, that she reported having chiropractic intervention after her fall, and that she reported having chiropractic intervention prior to her fall related to her neck. The records reflect that Petitioner underwent physical therapy for the timeframe of October 28, 2009 through December 17, 2009, at which time she was discharged. (PX11).

The medical records of Good Samaritan Regional Health Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 12. Petitioner underwent removal of plate, C4 to C6; exploration of fusion and then revision cervical discectomy, epidural decompression and fusion, C5-6, with right iliac crest autograft and anterior plating, C5-6 on August 11, 2014. The records reflect that Petitioner underwent a CT of the cervical spine on November 22, 2011, which was interpreted as revealing chronic and post-operative changes; no definitive spinal stenosis; neuroforaminal narrowing appears most severe at C5-C6. The Discharge Summary dated November 17, 2010 noted that Petitioner on November 16, 2010 underwent anterior cervical diskectomy, epidural decompression, foraminotomies bilaterally of C4-5 and C5-6d, interbody fusion of C4-5 and C5-6 with allograft bone spacers, local bone grafting and Vector-T plating. (PX12).

The Supervisor's Report of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The Witness Report of Ann Ashby was entered into evidence at

the time of arbitration as Respondent's Exhibit 3. The Google Maps image of the facility was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The Lease agreement was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of her employment with Respondent on December 16, 2008.

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC, ¶ 27; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. "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, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment." *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶ 21.

In the case at hand, the Arbitrator notes that Respondent has argued that Petitioner has not shown any increased risk because of her work as the area in which she fell was not utilized exclusively by Respondent's employees and that she was not within the scope of her employment at the time of her fall. The Arbitrator finds, however, that the evidence in this case demonstrated that as Petitioner was returning to her vehicle to retrieve her badge which was required for her to work, which the Arbitrator finds to be a reasonable activity in conjunction with her employment. Furthermore, the Arbitrator finds that the evidence in this case shows that Petitioner was restricted to parking in the south lot and was required to use the employee entrance, and that the area just outside the employee entrance was hazardous given the ice that had formed in a depressed area just outside the door. As a result thereof, the Arbitrator finds that Petitioner was exposed to the risk of falling to a greater degree than that faced by the general public.

As a result thereof, the Arbitrator finds that Petitioner met her burden of proof in establishing that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on December 16, 2008.

With respect to disputed issue (J) pertaining to reasonable and necessary medical expenses, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary, and causally related to her work accident of December 16, 2008. As agreed to by the parties at the time of arbitration, no medical bills remain outstanding.

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the timeframes of November 16, 2010 through March 2, 2011 and August 12, 2014 through December 1, 2014. Furthermore, the Arbitrator finds that Respondent is entitled to a credit of $14, 653.41 for temporary total disability benefits already paid. (AX1).

With respect to disputed issue (L) pertaining to nature and extent, the Arbitrator notes that Petitioner's injuries occurred on December 16, 2008 and, as such, the Arbitrator will not specifically be addressing the five factors under Section 8.1b of the Act in the determination of permanent partial disability.

The Arbitrator finds that the medical records in this case demonstrate that Petitioner underwent both conservative and operative treatment to her cervical spine as a result of this accident. Having reviewed the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 30% loss of use of the person-as-a-whole under Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Diane M. Garbin,
Petitioner,

18IWCC0164

vs.

NO: 14 WC 34694

Illinois Dept. of Human Services,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical, causal connection, 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 27, 2016, is hereby affirmed and adopted.

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

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

DATED: MAR 19 2018
o3/8/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0164

GARBIN, DIANE M
Employee/Petitioner

Case# **14WC034694**

ILLINOIS DEPT OF HUMAN SERVICES
Employer/Respondent

On 10/27/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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SPRINGFIELD, IL 62794-9208

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

OCT 27 2016

RENALD A. RASOIA, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0164

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

Diane M. Garbin,
Employee/Petitioner

v.

Illinois Department of Human Services,
Employer/Respondent

Case # **14** WC **34694**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **August 23, 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 **September 16, 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 **$80,848.02**; the average weekly wage was **$1,554.77**.

On the date of accident, Petitioner was **48** years of age, *single* with **0** dependent children.

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

Respondent *has* 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 amounts paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove by a preponderance of the credible evidence that her current condition of ill-being in her low back is causally connected to the injury of September 16, 2013. 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

October 22, 2016
Date

OCT 27 2016

Diane M. Garbin v. Illinois Department of Human Services, 14 WC 34694

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner presented to Dr. Narla on November 13, 2013 in follow-up for cervical pain and possible bilateral carpal tunnel syndrome. It appears she had previously been seen by him and was taking Flexeril and Mobic for her complaints. A steroid injection had helped significantly. She mentioned no lower back pain complaints. She was to return in six months unless there was a progression of her symptoms. According to Petitioner's past medical history, she had a history of joint pain localized in her hip and lower back pain.(PX 3)

Petitioner returned to see Dr. Narla on May 28, 2014. At that time they discussed three medical conditions, two of which were her C5-6 degenerative disc disease with left-sided radiculopathy and the other was her bilateral carpal tunnel syndrome. Petitioner reported "hardly any pain" regarding her neck due to her medications. Dr. Narla further noted that "Since September 2013 after lifting a heavy box, [Petitioner] started having a significant amount of pain in the gluteal area radiating down on the left side from the back itself, typical features suggestive of lumbar radiculopathy, most likely to be L5/S1 secondary to an L5-S1 paracentral disc herniation." (PX 3) Dr. Narla noted that it appeared to have settled down and her current pain was mostly localized in the lumbosacral area. Straight leg raising was somewhat uncomfortable around 60 degrees on the left side; the right side was normal. No sensory or motor deficits were noted. Forward flexion was full. The doctor's impression was lumbar radiculopathy on the left side, possibly an L5-S1 paracentral disc herniation. He also noted her diagnoses of cervical disc disease and bilateral carpal tunnel syndrome. Petitioner was advised to continue with the Mobic and Flexeril and he ordered physical therapy for the back. (PX 3)

On May 29, 2014 Petitioner's supervisor, Deborah K. Johnson-Small, completed a Supervisor's Report of Injury or Illness (PX 2). The date of accident was listed as "09/19/2013 approximately" and a "?" was put by the hour. Ms. Johnson-Small did not witness the accident and notice was received orally. Ms. Johnson-Small described the accident as "While searching through stacked boxes, lifted a box and heard a crack." Petitioner claimed lower back pain. Patricia Moreno was identified as a witness. A written job description was attached to the Supervisor's Report of Injury. (PX 2)

Petitioner underwent physical therapy from June 13, 2014 through July 29, 2014. (PX 4) At the time of her initial appointment Petitioner gave a history of low back problems since mid-September when she lifted a heavy box of files at work and heard a pop in her lower back. She had pain into her left buttock for a couple of weeks and then it started going down her leg to her knee and October was probably the worst month. Sleeping had been difficult but now she was feeling constant buttock pain but no numbness or tingling in her leg. Petitioner noted that when she tried to stretch her leg out while walking, descending stairs, sitting too long, or bending over with something heavy it tended to bring on the buttock pain. She reported taking Mobic and cyclobenzaprine for her neck. Petitioner reported sitting all day at work but trying to walk three or four times a day for breaks and lunch and using an elliptical at night. On physical exam, straight leg raising was negative. Repeated extension and standing ten times increased her back and buttock pain. Side bending to the left increased her buttock and back pain as did rotation to the right. Hip

adduction strength and hip extension strength was 4/5 bilaterally. Petitioner was given a home exercise program and underwent therapy at the Clinic. She was to be seen twice a week for four weeks. (PX 4)

As of June 18, 2014 Petitioner was reporting improved pain to the therapist. She noted pain dependent upon motion and increased neck pain due to some of the exercises stressing the back of her head. (PX 4)

As of June 20, 2014 Petitioner reported to the therapist that she was feeling fairly well with no new complaints. (PX 4)

When seen in therapy on June 23, 2014 Petitioner reported trying to get on her bike and noticing the motion of lifting her hip up and over caused pain shooting from the center of her back to her glute. (PX 4)

When seen in therapy on June 26, 2014 Petitioner reported ongoing pain with rotational motions. She reported going to pick a paper up off the ground and noticing a "twinge" of pain in her glute. (PX 4)

Petitioner attended physical therapy on June 30, 2014. (PX 4)

At her physical therapy appointment on July 3, 2014 Petitioner reported doing a little better only because her pain was no longer "constant." Nevertheless, she reported the pain could be easily brought on by certain movements, especially back movements like bending and twisting. (PX 4)

As of July 7, 2014 Petitioner told the therapist she was feeling the same. (PX 4)

When seen in physical therapy on July 10, 2014 Petitioner reported intermittent buttock pain; however, it wouldn't take much to cause it to return. (PX 4)

According to the therapy note of July 15, 2014 Petitioner reported her buttock pain was gone for two days after traction. She was performing her home exercises. (PX 4)

In the therapy note of July 24, 2014 Petitioner reported doing a little better since starting the traction. She still reported buttock pain with bending over and twisting, however. (PX 4)

Petitioner's final therapy visit was held on July 29, 2014. At that time Petitioner reported she wasn't having pain on a daily basis. It appeared more positional in nature, especially when sitting with her left leg under her. Petitioner had been performing her exercises except for the past week when she was so busy. She reported the traction was helpful. Petitioner had met all goals and was advised to continue with her home exercise program. If she felt her pain was returning or getting worse she was advised she could return for a couple more traction treatments. If the therapist didn't hear from her in the next 2-3 weeks, Petitioner would be discharged from formal physical therapy. (PX 4)

Petitioner returned to see Dr. Narla on August 6, 2014. At that time he noted that physical therapy had helped Petitioner's back along with traction. She denied any pain at the time of the exam and reported her medications were helping. Straight leg raising was normal. Forward flexion was full. No sensory or motor deficits were noted. Petitioner was advised to continue with the Flexeril and Mobic and if there was any worsening of her condition she was to contact the doctor for an MRI. Until then, no MRI was felt necessary. She was told to continue with her home exercises also and to return in three months. (PX 3)

Petitioner underwent a lumbar spine MRI on September 26, 2014. It revealed severe facet arthropathy at L4-5, mild anterolisthesis, and a synovial cyst projecting off the left superior articular process of L4. Overall, moderate spinal stenosis with proximal left foraminal and lateral recess narrowing was present. (PX 3)

Petitioner underwent a left-sided L4-5 epidural steroid injection on October 9, 2014 due to L4-5 severe stenosis producing a left-sided radiculopathy. Depending upon her response a second injection was to be given in three weeks. (PX 3)

On October 4, 2014 Petitioner filed her Application for Adjustment of Claim herein alleged that she injured her lower back lifting boxes on September 15, 2013. (PX 1)

Petitioner underwent a second left-sided L4-5 epidural steroid injection on October 30, 2014 due to L4-5 severe stenosis producing a left-sided radiculopathy. (PX 3)

Petitioner was re-examined by Dr. Narla on November 25, 2014 regarding her lumbar back pain. According to his notes Petitioner had been helped by the steroid injections but was reporting the pain had returned the day before after three weeks of relief. Dr. Narla advised her she could undergo one more injection within a six month time frame. Forward flexion was nearly full. Straight leg raising was about sixty degrees on the left and eighty degrees on the right. No sensory or motor deficits were noted. Dr. Narla's diagnosis remained unchanged. He offered her Ultram to be used as needed along with continued use of the Flexeril. She was to return in six months unless things worsened and she wished to get another steroid injection. He noted that if injections did not help, surgery might be an option but she was not keen on at that the time. (PX 3)

Petitioner returned to see Dr. Narla on June 24, 2015 regarding her neck and back pain. She reported taking Mobic and Flexeril when necessary with no side effects. Ultram reportedly made her ill. Her pain was rated as "2/10" and "0/10" the day before. Dr. Narla noted "It can be on either side right or left currently." Dr. Narla's impression was an L4/5 disc bulge with bilateral radiating pain and C5/6 degenerative disc disease helped by physical therapy. Petitioner was advised to continue with her Mobic and Flexeril and to return in six months or sooner if she needed a steroid epidural injection in her low back. (PX 3)

Petitioner's case proceeded to arbitration on August 23, 2016. At the time of the hearing Petitioner amended the date of accident, without objection, from September 15, 2013 to September 16, 2013. The disputed issues were accident, notice, causal connection, medical bills, out-of-pocket medical expenses, and the nature and extent of Petitioner's injury. Petitioner and Deborah K. Johnson-Small were the only witnesses testifying.

Petitioner testified that she has worked for Respondent since 1984. Her current job with Respondent requires her to maintain CILA (Community Integrated Living Arrangement) logs for individuals with developmental disabilities. As such, she pays for services for individuals with developmental disabilities.

Petitioner testified that when she started her current position with Respondent in 2011, there was a considerable backlog and she began the process of pulling five years of terminated files from the filing cabinets and placing them in 47 file boxes. Petitioner testified that a lot of the files were half a drawer thick because they contained several years of individual rate changes.

Petitioner testified that on September 16, 2013, her supervisor, Debra Johnson-Small, requested that she grab a file from one of the file boxes which were stacked in co-worker Patricia Moreno's office. As Petitioner was moving her third box, she heard a crack in her lower back. Petitioner testified she immediately informed Moreno that she injured her back, and then reported the injury to Johnson-Small when she delivered the file to her. Nothing else was said and everyone went about their work. Petitioner testified that no one provided her any accident reporting forms to fill out at that time.

Petitioner denied having any problems with her lower back prior to September 16, 2013. Petitioner testified that she began self-medicating for her lower back injury because she had some medication on hand from a previous cervical back injury after a car accident. Petitioner testified that prior to September 16, 2013 she was treating with Dr. Narla for her cervical back and taking the prescriptions Mobic, Tramadol, and Cyclobenzaprine.

Petitioner testified that she saw Dr. Narla in November of 2013 for a regularly scheduled cervical spine examination. Petitioner testified that she did not mention the problem with her lower back during the visit.

Petitioner testified that she continued to self-medicate for her lower back problem after she saw Dr. Narla in November of 2013. Petitioner testified that it took several months to finish the moving of the boxes at work and it was probably well into 2014 when it was completed. Petitioner testified that in the spring of 2014 she had problems and, again, she had a regularly scheduled appointment with Dr. Narla but this time she mentioned her low back to him. Petitioner testified that he recommended physical therapy which she undertook. Petitioner denied any new injury to her low back after September 16, 2013.

Petitioner testified that "sometime in April of 2014" she reported her lower back injury to her supervisor and they filled out an injury report. Petitioner testified that she completed the Employee's Notice of Injury form on May 29, 2014. Petitioner testified that she did not put a date of injury on the form because she did not remember what day the accident occurred on. Petitioner thought the accident took place during the first part of the week of September 16, 2013. Petitioner also testified that after she fills out a report, her supervisor has to fill one out also.

Petitioner testified that her current treatment is medication and seeing Dr. Narla every six months. Petitioner testified that she is also still treating with Dr. Narla for her cervical back. Petitioner testified that, as a result of her accident in September of 2013 she cannot lift anything heavy or sometimes even small. Petitioner explained that the office recently moved and they were packing up their offices and even bending over putting stuff in boxes aggravated her injury. Petitioner has not taken any extended time off of work for the injury.

On cross-examination Petitioner acknowledged that she filled out RX 1 on May 29, 2014. She acknowledged that she didn't give a specific date of accident, only the month and year. Petitioner also acknowledged that she is still treating with Dr. Narla for her cervical complaints.

Petitioner's supervisor, Debra Johnson-Small, testified at arbitration on behalf of Petitioner. Ms. Johnson-Small no longer works for Respondent, having retired. Ms. Johnson-Small testified that in September of 2013, she was off of work for a few weeks, and returned to work the third week of September. Ms. Johnson-Small testified that in the summer of 2013 her office began a re-organization project for closed

and open files and there was a lot of moving of boxes and files. Petitioner was assisting Ms. Johnson-Small with the project and there was no clerical support so everyone had to do their own filing.

Ms. Johnson-Small testified that Petitioner mentioned to her that her back was hurting at some point after she had returned to work in September. She further testified that at some point later Petitioner mentioned that she was going to make a doctor's appointment and she thought it was related to lifting those boxes. Ms. Johnson-Small testified that she completed a Supervisor's Report of Injury. (PX 2) Ms. Johnson-Small testified that she wrote on the form that the date of injury was approximately September 19, 2013, because Petitioner had been lifting the boxes as needed and Johnson-Small did not know the exact date of injury. Ms. Johnson-Small testified that she completed the Supervisor's Report of Injury on May 29, 2014. Ms. Johnson-Small testified that the injury occurred the week she returned to work in September of 2013.

On cross-examination Ms. Johnson-Small testified that she did not remember when Petitioner informed her she was going to see the doctor for her low back injury. Ms. Johnson-Small testified that she filled out the Supervisor's Report of Injury because she had talked to Petitioner and wanted to make sure that Petitioner was covered because her back pain was not going away. Ms. Johnson-Small also testified that she did not remember if Petitioner approached her about her back pain a month before she completed the Supervisor's Report of Accident.

The Arbitrator concludes:

Issue (C) Did an accident occur on September 16, 2013 that arose out of and in the course of Petitioner's employment with Respondent?

Petitioner sustained an accident on September 16, 2013 that arose out of and in the course of her employment with Respondent. Petitioner testified that on September 16, 2013, she was working for Respondent and was involved in a department file re-organization. Ms. Johnson-Small, Petitioner's supervisor at the time, corroborated Petitioner's testimony as to the work going on in the office during the third week of September, that Petitioner was moving and lifting boxes in order to pull a file for her and that Petitioner reported injuring her low back while doing so to her. Petitioner also testified that she mentioned the incident to a co-worker. Respondent did not call that witness to testify.

While Petitioner may have testified that she could not recall the date of the accident when she filled out the Notice of Injury form in May of 2014 that does not negate a finding of accident. Petitioner was able to describe it at that time and pinpoint the time period to the third week of September of 2013. Her description of the accident has always been consistent and her supervisor has never questioned the accident or denied that Petitioner mentioned it to her after it occurred.

Issue (E) Was timely notice of the accident provided?

Petitioner provided timely notice of her accident to Respondent. Petitioner testified that she reported the accident to her supervisor immediately after it occurred on September 16, 2013. Her supervisor concurred. That Petitioner and her supervisor did not complete accident forms until May of 2014 does not mean timely notice of the accident wasn't provided. Petitioner orally informed the person in charge about the accident immediately after it occurred.

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

Petitioner failed to prove that her current condition of ill-being in her low back is causally related to her accident of September 16, 2013.

Based upon Dr. Narla's records of November 13, 2013, Petitioner had a prior history of hip and low back pain. Petitioner denied same at the hearing. No explanation for why Dr. Narla's records would contain that history was provided. Thus, there is some question as to Petitioner's credibility. Petitioner's records of prior treatment with Dr. Narla weren't made a part of the record.

Petitioner continued to work full duty after the accident and had no lost time on account of the accident. She did not seek any medical treatment for her low back until approximately eight months thereafter. During that time she continued to be involved in the re-organization project at work and had to lift and move boxes. When presenting to Dr. Narla in May of 2014 Petitioner reported significant pain in the gluteal area that radiated down on the left side suggesting an L5-S1 paracentral disc herniation. However, she reported it had settled down and her pain was now mostly localized in the lumbosacral area on the left. Therapy was ordered. At her initial therapist's visit Petitioner reported having left buttock pain for two weeks post-accident followed by radiating leg pain down to her knee with October being the worst month resulting in difficulty sleeping. At its worst, it was hard for Petitioner to get up and get going in the morning. Furthermore, she reported that when stretching her leg out while walking, going down stairs, bending over with something heavy or sitting too long, it caused pain in her buttocks. Petitioner reported that she sat all day at a desk while working, walked three or four times a day on her breaks and lunch, and used her elliptical at night. It is very troubling that Petitioner did not mention the accident to Dr. Narla when she saw him in November of 2013 especially since October had been such a troublesome month for her, per the therapist's note and, furthermore, she denied any knee pain to Dr. Narla when examined by him and mentioned problems with sleeping as it related to her arm and neck but failed to mention how it was affected by her back. It is further troubling that Petitioner's prior medical records with Dr. Narla were not included in the record, especially given his notation of a prior history of hip/back complaints.

Dr. Narla was not deposed. He provided no causation opinion. Given the gaps in treatment and suggestion in the record of prior back problems, a chain of events analysis won't support causation herein. Petitioner has the burden of proof on the issue of causation and failed to meet that burden. Petitioner's claim for compensation is denied and no benefits are awarded.

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 (L) What is the nature and extent of Petitioner's injury?

Issues (J) and (L) are rendered moot, given the Arbitrator's causation determination.

****

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

Andy Blakney,
Petitioner,

18IWCC0165

vs.

NO: 14 WC 35191

McLean County Sheriff's/Dept of Corrections,
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, permanent disability, temporary disability, medical, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

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

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

DATED: MAR 19 2018
o3/8/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0165

BLAKNEY, ANDY
Employee/Petitioner

Case# **14WC035191**

McLEAN COUNTY SHERIFF'S/DEPT OF CORRECTIONS
Employer/Respondent

On 11/1/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% 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:

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

0264 HEYL ROYSTER
DANA HUGHES
PO BOX 6199
PEORIA, IL 61601-6199

18IWCC0165

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Andy Blakney
Employee/Petitioner

v.

McLean County Sherrif/Dept. of Corrections
Employer/Respondent

Case # 14 WC 35191

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington, on September 27, 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 August 16, 2014, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $40,560.00; the average weekly wage was $780.00.

On the date of accident, Petitioner was 36 years of age, married with 2 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 $0.00 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

October 30, 2016
Date

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on August 16, 2014. According to the Application, Petitioner was "Injured at work" and sustained an injury to the "knee, leg and other parts of the body" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1).

Petitioner became employed by Respondent in 2009 and worked as a Correctional Officer. Petitioner testified that on August 16, 2014, he had just completed a headcount of the inmates and then walked into the day room. Petitioner was in the process of turning on the television when one of the inmates said something to him. Petitioner turned to answer the inmate and, when he did so, he sustained a "pop" in his right knee. Petitioner said he was wearing Under Armour shoes and that the floor surface he was standing on was a worn down section of carpeting.

Petitioner reported the accident to Respondent on August 19, 2014. At that time, Petitioner completed and signed an Employee Report of Injury. According to that report, Petitioner was in a standing position, turned and took a step. As Petitioner turned, he felt pain in his knee (Respondent's Exhibit 1).

On August 19, 2014, a Supervisor Incident Report was also prepared. According to that report, Petitioner was standing, took a step and felt pain in his right knee (Respondent's Exhibit 2).

At trial, Petitioner testified that the morning following the accident his knee was very painful. Petitioner also stated that he had a pre-existing medical condition of gout and that he initially attributed his knee symptoms to that condition.

Petitioner initially sought medical treatment on August 19, 2014, at OSF Medical Center where he was seen by Dr. John Kreckman. According to the medical record of that date, there was "...no known injury, heard a pop on Saturday, woke up Sunday and had pain." The record also noted that Petitioner "...was at work. Standing and simply twisted...." Dr. Kreckman suspected that Petitioner had sustained a meniscal injury and directed Petitioner to follow up with another physician (Respondent's Exhibit 5).

Petitioner subsequently sought treatment at McLean County Orthopedics where he was seen by Pamela Norris, a Nurse Practitioner, on August 21, 2014. Petitioner informed NP Norris that he heard a pop when he twisted his knee on August 16, 2014. NP Norris ordered an MRI scan (Petitioner's Exhibit 2).

The MRI was performed on August 28, 2014. It revealed a partial tear of the anterior cruciate ligament and chondromalacia of the patella (Petitioner's Exhibit 3).

Petitioner was seen by Dr. Joseph Norris, an orthopedic surgeon, on September 4, 2014. Dr. Norris opined that Petitioner had chondromalacia of the patella. Dr. Norris also observed that the MRI had revealed a partial ACL tear; however, he noted that this was not consistent with his findings on clinical examination. He ordered physical therapy and authorized Petitioner to work

light duty, specifically stating that Petitioner was not to have direct contact with inmates (Petitioner's Exhibit 4).

Dr. Norris subsequently gave Petitioner's right knee an injection of Synvisc. Petitioner's condition improved and Dr. Norris released Petitioner to return to work without restrictions effective September 20, 2014 (Petitioner's Exhibit 4).

Dr. Norris was deposed on March 10, 2016, and his deposition testimony was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner, Dr. Norris' deposition testimony was consistent with his medical records. He opined that the injury described to him by Petitioner aggravated the chondromalacia of the patella. In regard to the tear of the ACL noted in the MRI, Dr. Norris stated that, given the findings on examination, this was not a significant finding (Petitioner's Exhibit 1; pp 9-10).

On cross-examination, Dr. Norris stated that Petitioner had informed him that when he injured his knee, he was standing, took a step and twisted his knee. Dr. Norris agreed that the incident as described by Petitioner was actually an activity that essentially everyone does (Petitioner's Exhibit 1; pp 14).

At trial, Petitioner stated that he had returned to work for Respondent as a Correctional Officer. He testified that his right knee catches when he bends over and he wears a knee brace all of the time. Petitioner's gout has remained an ongoing problem for which he has continued to receive medical treatment.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment for Respondent on August 16, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the accident of August 16, 2014, was consistent with the Employee Report of Injury, Supervisor Report of Injury, and the histories given by Petitioner to the medical providers.

At the time of the accident, Petitioner was in the process of turning on a television when he turned to respond to an inmate who had spoken to him. There was no evidence of any type of physical confrontation between Petitioner and the inmate. Further, there was no evidence that Petitioner's shoes or the condition of the surface of the floor caused the accident.

When Petitioner turned, took a step to respond to the inmate, he was performing an activity of daily life.

For Petitioner to prove that this accident arose out of and in the course of his employment he must prove that his employment exposed him to a greater degree of risk than the general public. Caterpillar Tractor Co. v. Industrial Commission, 541 N.E.2d 665 (Ill. 1989).

The act of walking across a floor at the employer's place of business does not establish a risk greater than that faced by the general public. Illinois Consolidated Telephone Co. v. Industrial Commission, 732 N.E.2d 49 (Ill. App. 5th Dist. 2000).

Another activity of daily life is exiting a car. It has been held that this action likewise does not expose an employee to a risk greater than that confronted by the general public. Vill v. Industrial Commission, 814 N.E.2d 917 (Ill. App. 1st Dist. 2004).

In this case, the actions of Petitioner which caused him to sustain an injury to his right knee were not the result of any risk of injury greater than that of the general public.

In regard to disputed issues (E), (F), (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

Dalton Daniels,
Petitioner,

18IWCC0166

vs.

NO: 15 WC 31250

Kelly Construction,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 13, 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

MAR 19 2018

DATED:
o3/8/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0166

DANIELS, DALTON
Employee/Petitioner

Case# **15WC031250**

KELLY CONSTRUCTION
Employer/Respondent

On 12/13/2016, 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:

4535 DENNIS R ATTBERRY
ATTORNEY AT LAW
220 W MAIN CROSS
TAYLORVILLE, IL 62568

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

18IWCC0166

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

Dalton Daniels
Employee/Petitioner

v.

Kelly Construction
Employer/Respondent

Case # **15 WC 31250**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Douglas McCarthy, Arbitrator of the Commission, in the city of Springfield, on November 22, 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 August 4, 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 $39,000.00 the average weekly wage was $750.00.

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

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

RESPONDENT, BY AGREEMENT, IS TO PAY THE OUTSTANDING MEDICAL CHARGES OF DR. ETHIRAJ AND DR. FABRIQUE.

RESPONDENT IS ALSO ORDERED TO PAY THE PHYSICAL THERAPY CHARGES OF THE PANA COMMUNITY HOSPITAL FOR D.O.S. OF 10-20-15 THROUGH 11-17-15, PURSUANT TO THE FEE SCHEDULE.

PETITIONER'S REQUEST FOR PAYMENT OF THE CHARGES BY PANA COMMUNITY HOSPITAL FOR TREATMENT ON 8-30-15 IS DENIED.

PETITIONER'S CLAIM FOR PERMANENCY DENIED.

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

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

D. Dglas McEarly

Signature of Arbitrator

12-9-2016
Date

DALTON DANIELS v KELLY CONSTRUCTION
15 WC 31250

STATEMENT OF FACTS

The petitioner on August 4, 2015, was working as a Concrete Laborer for Kelly Construction at the Tate & Lyle facility in Decatur, Illinois. The petitioner had worked at Kelly Construction for few months prior to the injury in question.

On the date in question, the petitioner was cutting a center square of a concrete slab that was poured a day or two prior. He testified that the concrete slab was roughly 20x20, and the part he was cutting out was roughly 4x4 or 5x5. He testified that he was using a jack hammer to cut out the slab and a concrete saw to cut the rebar. He testified that the rebar holds the concrete together.

The petitioner testified that on the date of accident he was picking up all of the rebar because they cut a bunch of it and when he was picking up the last piece, it went through his fingers so he grabbed and pulled it, experiencing a squeezing sensation in his back. He testified that he noted a pulling sensation when he did that and went to lunch and then after lunch, he started shoveling the concrete and that's when his back started popping and pulling.

The petitioner testified that he went to the Medics at the plant and they sent him to Dr. Ethiraj.

The medical record from Dr. Ethiraj were admitted into evidence and revealed that the petitioner first went there on August 18, 2015. The history was of pain in the middle back and right side in the thoracolumbar region. He gave a history of pulling a bag and straining the back around 9:30 am and later the pain got worse when he was shoveling concrete with the pain being 7-8/10. He denied any radiation, no tingling, no numbness. Physical examination was performed and there was no midline or paraspinal tenderness. Range of motion, forward flexion, lateral flexion, and extension were all normal. Bilateral straight leg raising was negative. Reflexes were 2+ and no sensory impairment. The impression was thoracolumbar strain. He was advised to apply ice and was released to return to regular work with caution with bending, twisting and lifting. He was advised to apply ice to the area and use over-the-counter Motrin.

The petitioner testified that he then was seen by Dr. Fabrique. The report of Dr. Fabrique was offered into evidence and showed the petitioner was seen there August 21, 2015. The petitioner was seen there for recheck

pain in the right mid back. The diagnosis was thoracolumbar pain, right side; hematuria. He was released to return to his regular job and was advised to see a private physician regarding hematuria.

The petitioner testified that he followed up with his family physician, Dr. Dycoco in Pana. He testified that he saw his family doctor a week or two later.

The medical records from Dr. Virgilio Dycoco were admitted into evidence.

Dr. Dycoco's entry for September 25, 2015 indicates that urine obtained for Walmart drug screen.

The petitioner was then seen by Dr. Dycoco on October 19, 2015 for follow up of his low back pain. There was no tenderness. Straight leg raising was negative. There was soreness in the low back area. The impression was low back pain, persistent. He was advised to start on physical therapy.

The petitioner testified that he received rounds of physical therapy. He testified that he did improve after the first round, but it was still there so he received a second round.

The records from Pana Community Hospital showed that the first round of physical therapy was on October 20, 2015. It showed that therapy was provided October 20, October 27, October 30 and the second round on November 10, November 13, November 17, 2015.

The records from Dr. Dycoco revealed that the petitioner was seen on November 12, 2015 still having back pain, taking physical therapy. The impression was low back pain, possible muscle strain, continue with therapy.

The petitioner was seen by Dr. Dycoco on December 9, 2015 and the records revealed the petitioner was still having problems, some improvement with physical therapy. The diagnosis was lumbar muscular strain due to work injury.

EVIDENCE DEPOSITION OF DR. RAJESH ETHIRAJ

The evidence deposition of Dr. Ethiraj was taken on July 22, 2016. Dr. Ethiraj testified as to his qualifications as an Occupational Medicine Physician. He testified to his single evaluation. He testified that the petitioner had

complaints of back pain. He testified that the petitioner had a normal exam other than the reports of pain. The doctor testified that he diagnosed the petitioner with a lumbar strain/sprain.

EVIDENCE DEPITION OF DR. KEITH FRABRIQUE

The evidence deposition of Dr. Keith Fabrique was taken on July 6, 2016. Dr. Fabrique testified to his qualifications as an Occupational Medicine Physician. He testified that he did examine the petitioner on August 21, 2015. He testified that the petitioner complained of back pain. He testified that the petitioner had a normal neurological examination. He testified that he noted that the petitioner had dextroscoliosis. He testified that was a convexity of his thoracolumbar spine to the right. He testified that his diagnosis was thoracolumbar pain on the right side with an additional diagnosis of hematuria. He testified that he put no work restrictions on the petitioner and suggested some heat and over-the-counter medication. He testified that he did issue a letter dated October 1, 2015 finding the cause of the petitioner's symptoms were probably related to a single, non occupational diagnosis based on the lack of findings from a musculoskeletal standpoint in the lower to mid back and the presence of blood in his urine specimen. He felt based on those findings that the condition was not work related. He testified that he suggested to the petitioner that he follow up with his physician for the hematuria. He testified that if the petitioner had a back strain and that the back strain and hematuria would be two separate conditions. He testified that the hematuria could have been the result of a urinary infection or a kidney stone and could happen at any time without activity or with activity.

EVIDENCE DEPOSITION OF DR. VIRGILIO DYCOCO

The evidence deposition of Dr. Virgilio Dycoco was taken on June 8, 2016. The doctor testified that he graduated from Far Eastern University in the Philippines and that he was not Board Certified. He testified to his initial examination on October 19, 2015, testifying that the petitioner was complaining of low back pain. He testified that the only positive finding he saw in the records from St. Mary's Hospital was pain and that the petitioner's pain could have been brought about by the incident in question. He testified that hematuria is blood in the urine and that condition was totally separate from the petitioner's incident. He testified that that condition could cause back pain. He testified that the finding that he made at the time of his initial examination was soreness in the low back. He testified that he did order physical therapy. He testified that the petitioner follow-up with him on November 12, 2015 and that he recommended a functional capacity evaluation. He testified that

he saw the petitioner again on December 9, 2015 and there was improvement with physical therapy but the condition did not completely resolve. He testified that the petitioner has not come back to him for treatment.

On cross examination, Dr. Dycoco testified his practice was that of a general practitioner. He testified that the straight leg raising performed by Dr. Ethiraj was negative and that there was no way to disagree with the release to return to full duty by the earlier examining physicians. He testified that he could not really tell if the petitioner's pain was real or not. He testified that straight leg raising that he performed was negative. He testified that he did not give the petitioner a note to be off from work. He testified that he has not seen the petitioner since December 9, 2015 and he could not state at the time of his deposition what the petitioner's current condition of ill-being was.

The petitioner testified that he voluntarily left the employ of Kelly Construction and went to work for Clavins Dairy Farm. He testified that after working there for two weeks, filling up feed buckets, five gallons, his back started hurting. He testified that they didn't like the way he was doing his job and they fired him.

He testified that at the current time he is self-employed. He testified that he was certified in repairing washing machines, dryers and stoves. He testified that he takes out the parts that are not functioning and puts in the right parts and then resells them.

The petitioner testified that at the current time, on occasion he takes over-the-counter medicines. He testified that he still has pain, right side of the spine. He testified that he is active in his repair business and in taking care of his two children. He testified that he has pain with lifting and a squeezing sensation. He complained of tightness. He testified that when he bends down a lot, his back starts hurting. He testified that he is able to do his current job, it's just difficult at times, especially with it being, you know, heavy appliances. He testified that he does take care of his two children and when he changes their diapers on his knees or is bending over and tries to pick them up, he sometimes has symptoms in his back.

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

The Arbitrator finds the following:

On August 4, 2015, the petitioner testified to an incident where he was pulling on a rebar and experienced pain in his back. He said that he was seen for treatment by medical personnel onsite, and referred to Dr. Ethiraj.

He was seen by Dr. Ethiraj on August 18, 2015. He performed an examination with findings being within normal limits and diagnosed the Petitioner with a thoracolumbar strain. Dr. Ethiraj released the petitioner to return to full duty, advising him to be cautious with bending, twisting and lifting. He prescribed over-the-counter medication.

The petitioner was then seen by Dr. Fabrique on August 21, 2015 with Dr. Fabrique performing an examination, revealing normal findings, complaints of pain, releasing him to return to work, with advice to follow up with his personal physician for the hematuria. In his deposition, Dr. Fabrique felt that the petitioner's complaints of pain were not related to the incident at work but rather related to the hematuria.

The petitioner then came under the care of Dr. Dycoco who recommended physical therapy for his subjective complaints. Dr. Dycoco's office notes indicate that he saw the petitioner for treatment on three occasions from October 19, 2015 through December 9, 2015. His diagnosis was that of a lumbar muscle strain which he said was due to work injury. (PX 2) He testified that the work injury was a cause of the symptoms for which he treated the petitioner. (PX 3 at 11)

Records from the six physical therapy treatments received by the petitioner between October 20 and November 17, 2015 show consistent findings of pain from the lower thoracic region to the sacral region on the right side. (PX 4)

The petitioner left the employ of Kelly Construction on his accord and then began working at a dairy farm and then eventually self-employed repairing washers, dryers and stoves. The petitioner in his testimony, testified that he took the parts that weren't functioning out of the washers, dryers and stoves, and put the proper parts in to make them functional and then resell them. He testified that sometimes he had pain with the heavy lifting involved in the appliances.

There are no medical documents to show that the petitioner was restricted from his gainful employment.

The petitioner did submit to a urinalysis for the hematuria at Pana Community Hospital.

The Arbitrator would find that the petitioner sustained a soft tissue injury to his thoracolumbar spine as a result of the work related incident. The Arbitrator would find that the hematuria is not work related.

J. ☒ Were 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 Respondent has agreed to pay the outstanding charges of Dr. Ethiraj for August 18, 2015 in the amount of $78.00 under the fee schedule; medical bills showing zero balance and the medical charges of Dr. Fabrique for August 21, 2015 in the amount of $124.80 under the fee schedule.

The Arbitrator is unable to determine the nature of the treatment received by the petitioner at the Pana Community Hospital on August 30, 2015. No accompanying treatment records were offered into evidence, and no testimony was provided concerning the treatment. Accordingly, the Arbitrator does not award payment of said charges.

As to the physical therapy charges for October 20, October 27, October 30, November 10, November 13, November 17, 2015, the Arbitrator orders the Respondent to pay the same pursuant to the fee schedule. The Arbitrator incorporates by reference his above conclusions concerning causation with respect to these bills.

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

The Arbitrator finds that the petitioner did sustain a soft tissue injury to his thoracic lumbar spine with negative examinations by Dr. Ethiraj and Dr. Fabrique, with no positive findings other than pain by Dr. Dycoco.

The Arbitrator would note that the petitioner continued to work in physically-demanding jobs, first at the dairy farm and then in the petitioner's self-employment as a repairer and reseller of dryers, washers and stoves, with no restrictions. His subjective complaints at the time of hearing were not documented in any of the physicians' treating records, not supported by on-going care.

Regarding the factors set forth in Section 8.1b of the Act, the Arbitrator finds that there was no AMA rating report offered into evidence and that the petitioner was a 21 year old laborer with no evidence of a loss of future earning capacity. With respect to the fifth factor, the Arbitrator finds that there was no evidence of disability corroborated by treating medical records. The petitioner's has not sought any medical care since he saw Dr. Dycoco on December 9, 2015. While the doctor said that though there was some improvement with therapy, the petitioner's pain had not completely resolved. The examination notes from that visit were not placed into evidence. While the doctor noted pain on his prior examination of October 19, 2015, he also said the only objective test which he gave the petitioner, the straight leg raising test, was negative. (PX 3 at 21)

Based upon the five factors referenced above, the Arbitrator finds that the Petitioner is not entitled to an award for permanent partial disability.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joyce Miller,
Petitioner,

18IWCC0167

vs.

NOS: 10 WC 19710
13 WC 23655

IL Dept. of Human Services,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 6, 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.

MAR 19 2018

DATED:
o3/8/18
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 repetitive trauma accident or that her bilateral carpal tunnel

syndrome was related to her work activities, reversed the Decision of the Arbitrator, and denied compensation.

Petitioner is a case worker for the Illinois Department of Human Services. She ascribed her bilateral carpal tunnel syndrome to 15-years of computer work in which she typed more than six hours a day and because she had to "handle" at least seven files a day. One of Petitioner's treating doctors, Dr. Russell testified by deposition on January 31, 2013. He testified there are multiple causal factors for developing carpal tunnel syndrome. He gave Petitioner a handout on ergonomics at the workstation. His recommendation that she lower the keyboard was general and not based on his knowledge of her workstation. Dr. Russell testified that "most people think" that "ergonomics while typing [is] something that can aggravate or cause" carpal tunnel syndrome. If the station can be set up so the wrists are in a neutral position and the whole upper shoulder girdle is supported, that would probably alleviate the problem. He also noted that currently, people are on computers all day long, while in the past people had to perform activities other than typing on a typewriter. He opined that Petitioner's work activities of "the static positioning for long periods of time at the computer" for 15 years was a causal factor in her carpal tunnel syndrome.

On cross examination, Dr. Russell clarified that it was not the typing that caused carpal tunnel syndrome; "it's the positioning of the wrist." It is only when the wrist is in flexion or hyperflexion that typing becomes a cause of carpal tunnel syndrome. When a person rests or straightens the wrists, the swelling and pressure on the nerve decreases. Dr. Russell agreed that he never saw Petitioner's work station. He gives the ergonomics pamphlet to any clerical worker with carpal tunnel syndrome. He did not ask her questions about her work station. He also did not know whether she took "micro breaks" such as to answer the phone. He did not discuss her work activities with her "too much." He did not know how much time she spent typing. He based his causation opinion on her report of computer work for 15 years.

Respondent's Section 12 medical examiner, Dr. Vender, testified by deposition on December 14, 2012. Dr. Vender opined that there was no relationship between Petitioner's work activities and her right carpal tunnel syndrome. He did not believe that carpal tunnel syndrome is caused by typing or keyboarding. He based that opinion on his experience and common sense. He noted that he knew of no epidemiological studies that show an association between typing and carpal tunnel syndrome, "and there are many studies that demonstrate a lack of association between the two." As best as doctors know, half of carpal tunnel syndrome cases are idiopathic in nature. Contributing factors include age, gender, increased BMI, smoking, diabetes, and hypothyroidism. Petitioner would be considered overweight (5'5" & 180 lbs.), she is female, and she is a smoker.

It is my opinion that simply typing, by itself, does not cause or aggravate carpal tunnel syndrome. In my opinion there needs to be some forceful gripping, abnormal positioning of the wrist, and/or significant prolonged vibration in the hand/wrists. Petitioner did not prove or even allege any of those factors. Therefore, I find the causation opinion of Dr. Vender more persuasive than that of Dr. Russell. In addition, Dr. Russell admitted that he really had no idea exactly how much typing Petitioner did, he had no idea about the ergonomic status of her work space, and he did not know the way she flexed or extended her wrists while typing. He simply based his opinion on her reporting typing for 15 years. In addition, his testimony was equivocal, opining that typing could aggravate her condition. In my opinion, that is not sufficient to sustain Petitioner's burden of proving repetitive trauma accident and causation.

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.

DLS/dw
46

Deborah L. Simpson
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0167

MILLER, JOYCE
Employee/Petitioner

Case# **10WC019710**

13WC023655

IL DEPT OF HUMAN SERVICES
Employer/Respondent

On 5/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4535 DENNIS ATTEBERRY PC
220 W. MAIN CROSS
TAYLORVILLE, IL 62568

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

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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 6 - 2016

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

18IWCC0167

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

Joyce Miller
Employee/Petitioner

v.

IL. Dept. of Human Services
Employer/Respondent

Case # **10** WC **19710**

Consolidated cases: **13-WC-23655**

An *Application for Adjustment 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 **3/30/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/8/10 and 5/31/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$56,340.00**; the average weekly wage was **$1,083.47**.

On the date of accident, Petitioner was **44** 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 **$11,786.14** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** in non-occupational indemnity disability benefits, for a total credit of **$0**.

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

ORDER

The Respondent shall pay the Petitioner the sum of $650.08 per week for a period of 41 weeks as provided in section 8(e) of the Act, because the injuries sustained caused loss of use of 15% of the right hand and 5% loss of use of the left hand.

The Arbitrator awards no additional TTD than what has been paid.

The Arbitrator awards $ 704.30 in medical expenses pursuant to 8a and 8.2 of the Act, see attached.

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

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

Edmund Lee
Signature of Arbitrator

5/3/16
Date

MAY 6 - 2016

Joyce Miller
v.
IL. Dept. of Human Services

18IWCC0167

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

The Parties presented at arbitration disputing the following issues: accident, causal connection; TTD, Medical bills and the nature and extent of Petitioner's injuries. The Petitioner provided the only live testimony at hearing stating that she was currently 59 years of age. Petitioner testified that she has been employed with the Respondent, State of Illinois for over 20 years and over 15 years with the IL. Dept. of Human Services.

The Petitioner testified that at the time of her accidents, March 18, 2010 and May 31, 2012, her title was that of a Human Services Case Worker. The Petitioner presented a job description which was admitted into evidence as Pet. ex. 15. Petitioner's undisputed testimony was that her job duties consisted of typing at least 6 hours per day with the remainder of her work day writing, answering phones and grabbing case files. Petitioner testified that while she did receive a transfer to the Chicago area, her job duties remained the same until about a year ago. Since then she has been promoted and do a lot of traveling and training.

Petitioner testified that she started having symptoms about 6 months to a year prior to March 18, 2010. She testified that she was still able to perform her job. On or about March of 2010, the numbness was getting worse to where she sought treatment with Dr. Lafata at the Physicians Group associates. She testified that the symptoms was progressive in nature. Petitioner testified that the symptoms were worse by the end of each shift. She indicated that prior to March 18, 2010 but during the time period she was having symptoms, she did take a vacation and that the symptoms lessened.

Petitioner testified that an EMG was ordered. She received it on March 26, 2010. This confirmed she had Carpal Tunnel Syndrome. She was then referred to Dr. Robert Russell with the Heartland Plastic Surgery Center. (A copy of his records were admitted as Petitioner's Exhibit 8.) Dr. Russell initial evidence deposition was on January 31, 2013 was admitted as Petitioner's exhibit 9). The Petitioner presented with a history of symptoms of carpal tunnel syndrome. She had been doing computer work for the past 15 years or so. She had tried naproxen and splinting. Complaints of weakness. She indicated that throughout the day she has periodic issues with numbness and parethesias. Dr. Russell reviewed. the EMG report of March 26, 2010. He indicated that the results showed severe denervating, right carpal tunnel syndrome and moderate left sensory carpal tunnel syndrome. Physical examination was consistent with the EMG in that she had a severe tinel sign on the right, and mild on the left. (Pet. Ex. 8 and Pet. ex 9 pgs. 6-7.). Based upon the examination and EMG, Dr. Russell diagnosed the Petitioner with

bilateral carpal tunnel syndrome, worse on the right than the left. (Pet. Ex. 8, and Pet. ex. 9, pg. 9). Dr. Russell recommended surgical release on the right.

Dr. Russell testified at length as to the Petitioner's work duties, specifically, typing, attributed to her development and aggravation of carpal tunnel syndrome. Dr. Robert Russell opined that the positioning of one's hands during typing, ergonomics, can lead to carpal tunnel if one is typing for hours or extended hours on a computer. It is based upon the flex or extension of the wrists wherein there is a change in the volume or the diameter of the carpal tunnel. (Pet. Ex. 9, pgs. 12-13; pgs. 41-42. He further testified that the fact that she was in an office setting and typed over 15 years also assisted him in coming to the conclusion that her typing contributed to the fact that her work was a contributory factor in developing carpal tunnel syndrome. (Pet. Ex. 9, pg. 14). He testified that he gave an ergonomics worksheet to the Petitioner to take back to her employer to address the ergonomics in the work station. (Pet. ex. 9, pg. 43. Petitioner testified that her employer never implemented the changes. On cross-examination, Dr. Russell was asked about other possible contributory factors. While he conceded that smoking, weight and being a female probably contributed to the problem, he again reasserted that working on a computer for 15 years "would have to be considered at least a contributing factor". Pet. Ex. 9 Pgs. 50-51. In his second evidentiary deposition on June 12, 2014, Dr. Russell testified that 4 to 6 hours of typing a day was enough to lead to or aggravate carpal tunnel syndrome. (Pet. Ex. 10. pg. 20.) *See also* Dr. Russell testimony on May 20, 2015 in his third deposition. (Pet. Ex. 11 pg. 10). Petitioner testified that she typed at least 6 hours per day. Her testimony was unrebutted.

Dr. Russell testified that he sent a request to worker's compensation for approval. He also presented the Petitioner an ergonomic information sheet to give to the employer so that they can modify her work station. (Pet. ex. 8 and Pet. ex. 9 pgs. 12-13.)

The approval was granted by the Respondent on July 7, 2010. A copy of the approval was admitted into evidence as Pet. Ex. 1.

Petitioner testified that she relied upon Dr. Russell's recommendation and the Respondent's approval to obtain the right carpal tunnel release. The surgery was completed on July 16, 2010. The operative procedure was a right open carpal tunnel release with release of the guyan canal. (Pet. ex. 7.). The surgery helped. On August 3, 2010, the left carpal tunnel release was discussed but no plan of action occurred on that date. The Petitioner followed back up with Dr. Russell on August 10, 2010. do to persistent complaints in the right hand, Dr. Russell also gave an injection into the right thumb. (Pet. Ex. 8) She was returned back to work. Petitioner testified that she tried to go back to work but was sent home because she was getting symptoms back in her right hand as she tried to type. Dr. Russell gave her a light duty release of no use of the right hand. The Petitioner testified that her employer was not able to accommodate the restrictions because she was unable to type with just one hand. (Pet. Ex. 8). During this time period, Dr Russell also prescribed physical therapy and work hardening.

Petitioner again attempted to go back to work on September 6, 2010. Petitioner testified that she has a case quota to reach each day. Given her symptoms in her right hand, she was unable to type enough to keep up with her quota and her employer sent her home.

Petitioner returned to Dr. Russell on December 7, 2016. The work hardening and physical therapy had helped. While still not pain free, she was able to return back to work. Petitioner had a second EMG done on 11/24/2010. The results were (1) left carpal tunnel syndrome and (2) status post right carpal tunnel syndrome with significant improvement. Dr Russell indicated that given the symptoms and the EMG report, a left carpal tunnel release was reasonable and forwarded a request for approval to the Respondent. (Pet. Ex. 8).

The approval was granted by the Respondent on February 2, 2011. A copy of the approval was admitted into evidence as Pet. Ex. 2.

Petitioner testified that prior to obtaining surgery on her left hand, she was transferred to the Chicago area with the Respondent. Petitioner testified that Dr. Russell referred her to Dr. Terry Light with the Loyola University. This was done on June 14, 2011. (A copy of Dr. Light records were admitted into evidence as Pet. Ex. 12.) Petitioner testified that her left hand continued to have symptoms and her right thumb was getting worse. On May 31, 2012, Dr. Light gave the Petitioner a splint for the right thumb. Petitioner followed back up with Dr. Light on July 5, 2012. On that date, Dr. Light diagnosed the Petitioner as having Dequeirsvain Tenosynovitis and carpal tunnel syndrome. A splint was prescribed. (Pet. Ex. 12.) Petitioner followed up with Dr. Light on November 1, 2012. This was her last visit with Dr. Light. Petitioner testified that Dr. Light indicated that surgery was the only option. She wanted to have Dr. Russell do the surgery.

Petitioner returned to Dr. Russell on February 19, 2013. He once again recommended surgery. The Respondent then had the Respondent seen by a section 12 examiner, Dr. Michael Vender. (A copy of his deposition was admitted as Resp. ex. 1). Dr. Vender testified that he does not believe typing can cause carpal tunnel regardless of the ergonomics of the work station. (Resp. Ex. 1, pg. 15., Pg. 39). Based upon this, Dr. Vender indicated that the Petitioner's work is not causally related to her carpal tunnel syndrome. (Resp. Ex. 1, pg. 15) Dr. Vender also had the Petitioner undergo an EMG. A copy of which is admitted as Resp. Ex. 1. The results were that the Petitioner was on the high side of normal. Petitioner said that when they conducted their EMG, they did not finish because she was in too much pain.

On May 29, 2013, Dr. Russell wrote a causation letter indicating that the work was a causative factor and that the Petitioner needed a left carpal tunnel release. (Pet. Ex. 3).

Dr. Russell was asked in his June 12, 2014 deposition whether he still believed that the Petitioner needed left carpal tunnel release. He testified that he needed a new EMG study. This was done on March 13, 2015. See Pet. Ex. 6. The report indicates that the Petitioner still has carpal tunnel syndrome. It is recommended in the report that the Petitioner undergo a left carpal tunnel

release. The right hand was doing very well. (Pet. Ex. 6.). Dr. Russell testified that he reviewed the EMG and the Petitioner's complaints and recommended surgery. (Pet. Ex. 11, pgs. 6-8).

Petitioner last seen Dr. Russell on June 30, 2015. On examination, Dr. Russell noted that the Petitioner still has some symptoms related to carpal tunnel syndrome. She had a positive Tinel's, positive median nerve compression test. He recommended the release. (Pet. Ex. 8).

Petitioner testified that since the June 30, 2015 visit, she has received a promotion. Her new job duties do not require as much typing and her symptoms have become manageable. She does not want to go forward with surgery. She still has pain, numbness and tingling of the left hand. Her right thumb still hurts. She is right hand dominant. She notices symptoms when she attempts gripping tasks such as opening jars or soda bottles. Fixing her hair, doing laundry and dishes also produce symptoms. She notices achiness with weather changes. She takes aleve once per day. She has occasional sleeping issues relative to her symptoms. She notices additional symptoms when mowing her lawn and gripping steering wheel when driving. She does a lot of driving now for work.

The Arbitrator Concludes:

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

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

In a repetitive trauma case, issues of accident and causation are intertwined. ***Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture,*** 99 I.I.C. 0961. "The Word 'accident' is not a technical legal term, and has been held to mean anything that happens without design, or an event which is unforeseen by the person to whom it happens...Compensation may be allowed where a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." ***Laclede Steel. Co. v. Industrial Comm.,***6 IU.2d 296 at 300, 128 N.E. 2d 718, 720 (1955) citing ***Baggot Co. v. Industrial Comm.,*** 290 Ill. 530, 125 N.E. 254 (1919). Under Illinois law, an injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. ***Sibro Inc. v. Indus Comm'n,*** 207 Ill. 2d 193, 2015, 797 N.E. 2d 665 (2003). Even when other non-occupational factors contribute to the condition of ill-being, "[A] Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." ***Fierke v. Indus. Comm'n,*** 309 Ill.App.3d 1037, 723 N.E. 2d 846 (3rd Dist., 2000). Allowing a claimant to recover under such circumstances is a corollary of the principal that employment need not be the sole or primary cause of ac claimant's condition. ***Land & Lakes Co. v. Indus. Comm'n,*** 834 N.E. 2d 583 (2nd Dist. 2005. (Employers are to take their employees as they find them. ***A.C. & S. v. Industrial Comm'n,*** 710 N.E. 2d 837 (1st Dist., 1999) citing ***General Electric Co. v. INdustrial Comm'n***, 433 N.E. 2d 461, 672 (1982). The Supreme Court in ***Durand v. Indus. Comm'n***, noted that the purpose of the Illinois

Workers' Compensation Act is best served by allowing compensation where an injury is gradual but linked to the employee's work. ***Durand v. Indus. Comm'n,*** 862 N.E.2d 918, 925 (2006).

In the repetitive trauma case of ***Fierke,*** the Appellate Court specifically applied the foregoing legal standard of causation specifically to a repetitive trauma case and noted that non-employment related factors that contribute to a compensatory injury do not break the causal connection between the employment and a claimant's condition of ill-being. ***I.d.*** at N.E. 2d at 849. The Court specifically stated, "the fact that other incidents, whether work related or not, may have aggravated a claimant's condition is irrelevant." ***id.***

The Appellate Court's decision in ***Edward Hines Precision Components v. Indus. Comm'n,*** highlights that there is no standard threshold which a claimant must meet in order for his or her job to classify as sufficiently "repetitive" to establish causal connection. ***Edward Hines,*** 365 IU.App.3d 186, 825 N.E. 2d 773, 292 Ill.Dec. 185 (2nd Dist. 2005). ***Edward Hines,*** 365 IU.App.3d 186, 825 N.E.2d 773, 292 Ill.Dec. 185 (2nd Dist. 2005). In fact, the Court expressly stated, "there is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." ***Id.*** at N.E.2d 780. Similarly, the Commission recently noted in ***Dorhesca Randell v. St. Alexius Medical Center,*** 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before finding a repetitive trauma can be made. ***Randle*** citing ***All Steel, Inc. Indus. Comm'n,*** 582 N.E.2d (1991) and ***Edward Hines supra.***

Furthermore, in support of a finding of causal connection, the Arbitrator notes that the job duties performed by Petitioner, including computer keyboarding and data entry have been held to be compensable by the Commission in the very recent past. *See* ***Lewis Debout v. State of Illinois/Pinkneyville Correctional Center,*** 14 IWCC 0167 (2014); ***Toma Osman vv. State of IL/Tamms Correctional Center,*** 11 IWCC 0601 (2011); ***Cynthia Jenkins v. State of IL/Southern Illinois University, Carbondale,*** 14 IWCC 0335 (2014); ***Nancy Rambo v. State of IL/Department of Transportation,*** 12 IWCC 1020 (2012).

In this case, the Petitioner testified that she types 6 hours per day. She has done this for over 15 years. She notes that her symptoms were worse at the end of the shift. The Petitioner testified that when she went on vacation and didn't type her symptoms lessened. She also testified that once she was promoted and was doing less typing her symptoms also lessened. Dr. Robert gave a causation opinion that typing contributes to the development of carpal tunnel syndrome. Dr. Russell opined that the positioning of one's hands during typing, ergonomics, can lead to carpal tunnel if one is typing for hours or extended hours on a computer. It is based upon the flex or extension of the wrists wherein there is a change in the volume or the diameter of the carpal tunnel. (Pet. Ex 9, pgs. 12-13; pgs. 41-42. He further testified that the fact that she was in an office setting and typed over 15 years also assisted him in coming to the conclusion that her

typing contributed to the fact that her work was a contributory factor in developing carpal tunnel syndrome. (Pet. Ex. 9, pg. 14). He testified that he gave an ergonomics worksheet to the Petitioner to take back to her employer to address the ergonomics in the work station. (Pet. ex. 9, pg. 43. Petitioner testified that her employer never implemented the changes. On cross-examination, Dr. Russell was asked about other possible contributory factors. While he conceded that smoking, weight and being a female probably contributed to the problem, he again reasserted that working on a computer for 15 years "would have to be considered at least a contributing factor". Pet. Ex. 9 Pgs. 50-51. In his second evidentiary deposition on June 12, 2014, Dr. Russell testified that 4 to 6 hours of typing a day was enough to lead to or aggravate carpal tunnel syndrome. (Pet. Ex. 10 pg. 20.) *See also* Dr. Russell testimony on May 20, 2015 in his third deposition. (Pet. Ex. 11 pg. 10). Petitioner testified that she typed at least 6 hours per day. Her testimony was unrebutted.

Dr. Vender was called as a section 12 examiner by the Respondent. He testified that typing cannot cause carpal tunnel and that ergonomics cannot cause carpal tunnel. Resp. Ex. 1, pg. 15,, Pg. 39). Dr. Russell testified that he disagreed with Dr. Vender that the ergonomics of typing cannot cause or contribute to carpal tunnel. (Pet. Ex. 9, pg. 14).

Dr. Light's records indicate that the Petitioner's job duties including lifting files caused or aggravated her DeQuervain's Tenosynovitis. (Pet. Ex. 12).

The Arbitrator finds the Petitioner to be a credible witness who testified credibly on her own behalf regarding the details of her job duties, and also notes that her testimony was consistent with the job descriptions which were admitted as Pet. Ex. 15. She testified that she typed for at least 6 hours per day for over 15 years. She also testified that her ergonomics of her work station was never addressed. The arbitrator notes that the timing of her symptoms were also a factor in determining the relationship between her job duties and her carpal tunnel. Petitioner testified that the symptoms were worse at the end of a shift. She also noted some relief when she was on vacation. She also indicated that her new position with the Respondent involves less typing and has lessened the symptoms to where she believes she can live with the symptoms and not have to have surgery. The Arbitrator finds Dr. Russell's explanation of the correlation between the anatomy of the hand during typing with the development of carpal tunnel syndrome more compelling than Dr. Vender's analysis that typing, even with poor ergonomics, cannot cause carpal tunnel.

Petitioner testimony regarding her current symptoms is found to be credible.

For the reasons stated herein, the Arbitrator finds the causation opinion of Dr. Russell to be credible and finds that the Petitioner met her burden of proof in establishing that she sustained accidental injuries that arose out of and in the course of her employment with Respondent which are causally related to her current condition of ill-being.

Issue (J): Were the Medical Services that were provided to the Petitioner reasonable and necessary? Has the Respondent paid all appropriate chares for all reasonable and necessary services?

The Arbitrator finds that since the Petitioner met her burden that her current condition of ill-being was reasonably related to the accident, all reasonable and necessary bills are to be paid. The Parties do not dispute the reasonable or necessity of the treatment up through the date of the Arbitrator only causal connection. The Petitioner's known unpaid medical bills are as follows:

(a) Loyola Univ Medical Center: $502.30

(b) Physicians Group Associate: $202.00

The Respondent is to pay these bills pursuant to the medical fee schedule.

Issue (K): What temporary benefits are in dispute (TTD)

The Petitioner provided off work slips which notes that the Petitioner was either off work or was given light duty (which the employer would not accommodate) from 8/20/2010 to 8/29/2010, 9/2/2010 through 9/5/2010, 9/7/2010 through 11/21/2010. The Parties agree that the Respondent has paid for the time off work. However the Respondent has argued that the Petitioner did not sustain an accident that arose out of her employment and if she did, the time off work was excessive.

In this case, the Arbitrator finds that since he found that there was an accident that arose out of the course of employment, Respondent's first argument is without merit. As for the second part of the Respondent's argument that the Petitioner took too much time off work, the Arbitrator first looks to the off-work slips. (Pet. Ex. 13.) The off work slips along with the unrebutted testimony of the Petitioner that the employer would not accommodate light duty are consistent with the dates that are listed herein for her time off work.

The Arbitrator next looks to the merit of the argument that the Petitioner's off work was excessive. The Arbitrator notes that the Petitioner attempted to return to work not once, but twice. Each time, given her symptoms, it was the employer who sent the employee home. Based upon the foregoing, the Arbitrator finds that the Respondent was required to pay for time off work from 8/20/2010 to 8/29/2010, 9/2/2010 through 9/5/2010, 9/7/2010 through 11/21/2010. Respondent has paid this and they are therefore getting credit for $11,786.14 in TTD Payments.

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

8.1 b(b) (i) of the Act: No impairment report was offered into evidence so no weight iis given to this factor.

(ii); The Petitioner is still employed with the Respondent as a staff development specialist which is a less physically demanding position. The Arbitrator give moderate weight to this factor.

(iii) The Petitioner was 44 years old at the time of the accident. The Arbitrator gives this factor no weight as there was no evidence how this affects her disability.

(iv) The Petitioner earns more from her employment with the Respondent than before her injuies. The Arbitrator gives this moderate weight.

(v) The Arbitrator notes that the Petitioner had a carpal tunnel release on the right hand and was issued a splint for the right thumb related to her DeQuervain's Tenosynovitis. She has also had injections into the thumb. Petitioner treated conservatively on the left hand. Though surgery was recommended, given her new job, Petitioner believes that at this time, she can live with the symptoms. She still has pain, numbness and tingling of the left hand. Her right thumb still hurts. She is right hand dominant. She notices symptoms when she attempts gripping tasks such as opening jars or soda bottles. Fixing her hair, doing laundry and dishes also produce symptoms. She notices achiness with weather changes. She takes Aleve once per day. She has occasional sleeping issues relative to her symptoms. She notices additional symptoms when mowing her lawn and gripping steering wheel when driving. She does a lot of driving now for work. The Arbitrator gives significant weight to this factor.

Based upon the foregoing, the Arbitrator finds that the Petitioner has sustained a 15% loss of use of the right hand and 5% loss of use 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

Leif Roady,
Petitioner,

18IWCC0168

vs.

NO: 12 WC 30286

G&S Foundry,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §§19(b)/8(a) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical, 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. 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.

18IWCC0168

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $51,900.00. 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: MAR 19 2018
o3/8/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0168

ROADY, LEIF
Employee/Petitioner

Case# **12WC030286**

G&S FOUNDRY
Employer/Respondent

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:

0384 NELSON & NELSON
DAVID C NELSON
420 N HIGH ST PO BOX Y
BELLEVILLE, IL 62222

1454 THOMAS & ASSOCIATES
ROBERT A HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

18IWCC0168

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

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

LEIF ROADY
Employee/Petitioner

v.

G&S FOUNDRY
Employer/Respondent

Case # **12** WC **30286**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 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 _____

18IWCC0168

FINDINGS

On the date of accident, **April 16, 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 **$17,187.46**; the average weekly wage was **$330.53**.

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

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

Respondent shall be given a credit of **$47,844.98** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$47,844.98**.

Respondent is entitled to a credit for all medical expenses paid pursuant to Sections 8(a) and 8.2 of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $286.00 per week, the minimum statutory rate for a worker with two dependents (wife and one dependent child, per stipulation), for 173-2/7 weeks, commencing July 26, 2013 through June 30, 2014 and from December 4, 2014 through April 25, 2017, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $47,844.98 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services contained within Petitioner's Exhibit 13 as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for all awarded 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 Sections 8(a), 8(j) and 8.2 of the Act.

The Petitioner's request for prospective disc replacement and/or fusion surgery is denied at this time.

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.

18IWCC0168

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 22, 2017
Date

JUN 27 2017

STATEMENT OF FACTS

At hearing, Petitioner's wife, Lisa Roady, initially testified. Married to Petitioner for 12 years, she testified that she has spent significant time with the Petitioner and attended all of his medical visits other than therapy and a functional capacity evaluation (FCE), and has taken care of picking up and dispensing his medications as well.

With regard to Dr. Heffner's 6/30/14 (Rx5) progress note releasing Petitioner to work, Mrs. Roady testified that it also prescribed three weeks of physical therapy at Sparta PT and that her understanding of the note was that he was to return to full duty after this additional therapy was completed. The Arbitrator notes this document states: "He has three more weeks of physical therapy remaining and he will finish that out and then can be released to full duty without restrictions at maximum medical improvement." (Rx5). With regard to a 7/28/14 discharge note from Sparta PT indicating 15 visits and 3 cancelations, Mrs. Roady testified Petitioner always attended his scheduled visits, and the cancelations occurred when he showed up and therapy wasn't approved by the Respondent and he would reschedule. (Rx5).

Mrs. Roady testified that the Petitioner weighed over 150 pounds prior to the accident and roughly 130 pounds at the time of the 6/30/14 work release, with no other explanation for the weight loss. She testified that the Petitioner had been able to engage in heavy labor work and lift up to 100 pounds, and has been unable to perform these activities. Mrs. Roady agreed the Petitioner's leg pain diminished following Dr. Heffner's 2014 surgery, but that the limp that started after the injury did not go away. She testified the limp results in uneven wear on his shoes. The Arbitrator observed the bottoms of a pair of Petitioner's shoes, and agreed that a photo taken of same (Px15) accurately depicted what the Arbitrator saw. In the Arbitrator's view, both shoe soles were very worn; most significantly worn were the left outer heel and the right toe area, though the Arbitrator finds that the differences between the shoes are not so significant as to warrant proof of a limp to one side or another.

The Respondent's attorney indicated that the Respondent had already shut down when the Petitioner was released by Dr. Heffner in July 2014. The Petitioner attempted to return to work in approximately August 2014 in a temporary two week position at the Sparta Shooting Range in Sparta, Illinois. Mrs. Roady testified she would drive Petitioner to and from the job, as he felt unsafe to drive himself due to his ongoing right leg problems, and that he only completed a total of about 20 hours of work in that time. She testified Petitioner was unable to work the job without substantial pain, and that he sometimes called her to deliver medications to him there.

At this point, Mrs. Roady testified that she and the Petitioner sought further treatment to improve his functionality, and when Dr. Heffner indicated he had nothing more he could offer Petitioner. He referred Petitioner to pain management with Dr. Du, where Petitioner underwent injections, but Mrs. Roady indicated they provided only temporary relief. After obtaining new legal representation, Mrs. Roady testified that the attorney provided her with the names of some possible second opinion physicians. After she researched them and came up with two possibilities, she brought those names to Petitioner's primary care provider, who then referred Petitioner to orthopedic surgeon Dr. Gornet, and he has proposed an additional surgery.

The Petitioner testified on his own behalf as well. He testified that Px16 is a photo of a manipulator machine which is similar to what he was working on when he was injured, and explained that the photo contained as Exhibit A to Dr. Gornet's deposition (Px14) was a reenactment of the way his body was positioned while trying to operate a button on the machine when he was injured. He testified that he was pressing a button with his index finger on the manipulator arm to make it go up and down, but also had to use force to pull the manipulator in the horizontal plane, and estimated the force required was equivalent to the force required to move a 5 gallon bucket of water.

The Petitioner testified that he has not been pain free since the accident. He confirmed that after surgery with Dr. Heffner, while his constant shooting pain in the right leg improved, but he continues to have pain with weightbearing that shoots from his right hip to the inner right leg, and continues to limp. He also testified to what he called "bug feeling", which sounded like tingling in the muscular areas of his right leg, and that it is worse in the bottom of his foot. He testified the surgery did not help his low back pain. The Petitioner testified that he was present for his wife's testimony, and that he noted no inaccuracies in her testimony. The Petitioner wants to have the surgery with Dr. Gornet so he has a chance to return to his normal life.

The records reflect a prior 7/6/11 lumbar x-ray following a spontaneous onset of low back pain, and the films were normal other than a corticated cleft within the right L1 transverse process, a developmental feature. (Px9).

On 5/7/12, the records of Convenient Care noted a diagnosis including anxiety and depression and Wellbutrin was prescribed. There was no indication of back or leg pain at that visit. On 6/28/12 Petitioner reported an approximate one month history of right hip pain. A secondary note indicated low back pain and Petitioner reported lifting sand bags all day at work. (Px2). 8/17/12 lumbar x-rays showed early mild degenerative facet arthrosis at L5/S1, while hip and SI joint films were read as normal. An 8/14/12 lumbar MRI reflected focal disc pathology at L4/5 and L5/S1, and dominant disease at L4/5 creates mild impingement of the right L5 nerve root. (Px3).

Petitioner underwent lumbar epidurals with Dr. Chien on 9/7/12 and 9/14/12. At the initial visit a history of depression and panic attacks was noted, as well as that Petitioner had injured himself a year prior jumping off a roof, but had developed buttocks pain at work in April. (Px3). On 10/19/12 Petitioner noted he felt better with an occasional mild pinch in the right hip, and he was to follow up as needed. He returned on 11/9/12 indicating he bent down to pick up his son and developed mild bruising and a knot over his tailbone, as well as back spasms and shooting pain in the right leg. (Px5).

Petitioner was examined by Dr. Petkovich on 1/3/13 pursuant to Section 12. He diagnosed degenerative disc disease at L4/5 and L5/S1 as well as strains of the low back, right hip and groin, and that his symptoms at that time were the result of an exacerbation of the preexisting disc disease. (Rx2).

Petitioner was examined by Dr. Chabot on 2/27/13 (Note - while the report was addressed to Respondent's adjuster, Dr. Gornet's initial report of 3/24/16 indicates Petitioner reported it was his choice to see Dr. Chabot – see Px11). Intake forms noted low back, right hip and groin pain, as well as leg pain with weight bearing and weakness in the right leg. He denied numbness. Noting he had not yet reviewed Petitioner's MRI, and that there was a suggestion of symptom embellishment from Petitioner on exam, Dr. Chabot recommended a right SI joint injection, which the report notes was performed that day. Petitioner indicated he had been terminated by Respondent and had worked at another job with Spartan Light Metals as a die cast operator, and Dr. Chabot found it difficult to believe the Petitioner was working there "while exhibiting significant gait abnormalities and expressing his present level of distress", also noting Dr. Petkovich had indicated Petitioner was walking normally when he saw him the prior month. (Px8).

At 3/27/13 reevaluation, Dr. Chabot noted 8/23/12 MRI showed a right-sided L4/5 disc protrusion with facet and ligamentum flavum hypertrophy and stenosis, with a central herniation and high intensity zone at L5/S1. He recommended EMG/NCV testing. This was performed by Dr. Wayne on 4/29/13, who indicated it did not reflect radiculopathy or peripheral neuropathy. Petitioner visited Dr. Chabot again on 4/29/13, and the doctor noted the EMG/NCV results as well as an exaggerated right limp with normal neurological examination. Dr. Chabot indicated he spoke to Petitioner's physical therapist, who indicated he was restricting his own progress. Noting he discussed this with Petitioner and his wife and encouraged advancement in therapy, Dr. Chabot again opined that Petitioner was embellishing his symptoms. He recommended treatment with physiatrist Dr. Wayne. (Px8).

7/30/13 lumbar MRI indicated a moderate right paramedian disc protrusion at L4/5, perhaps slightly more prominent since the 8/23/12 study with likely nerve impingement and mild stenosis, and mild to moderate midline protrusion at L5/S1 with an annular tear. A 7/30/13 right hip x-ray indicates an intact right hip and suggestion of possible slight narrowing of the superior left hip joint space. (Px9).

Petitioner initially saw neurosurgeon Dr. Heffner on 9/12/13, reporting pain around the waist, and he had an antalgic gait. Petitioner indicated he had not worked since his work accident, and denied prior back or leg problems. Dr. Heffner noted his review of an MRI film showed minor abnormalities ("nothing that I would feel warrants surgical consideration on the basis of MRI alone"), and a CT/myelogram was prescribed. (Px9). Petitioner underwent a lumbar CT scan/myelogram on 9/24/13. The CT showed an annular bulge with right paracentral disc protrusion at L3/4, resulting in mild right lateral recess stenosis without impingement of the L4 nerve root. There also was a small disc protrusion at L4/5 and a transitional lumbosacral segment. No other areas of lateral recess, neuroforaminal or spinal stenosis or impingement were indicated. (Px6). The myelogram reported the transitional lumbosacral segment and mild ventral extradural deformities at L2/3 and L3/4 without significant spinal stenosis and the exiting nerve roots were unremarkable. (Px6). On 10/17/13, Dr. Heffner reviewed the CT/myelogram and noted the transitional L5/S1 segment as well as a right sided herniation at L3/4, which was a more significant finding than the MRI depicted, and he recommended L3/4 laminectomy/discectomy surgery. (Px9).

On 10/9/13, Dr. Petkovich examined Petitioner a second time. He noted obvious atrophy in Petitioner's right leg and agreed with the recommended CT/myelogram, also recommending a right hip MRI. (Rx2).

The 12/5/13 right hip MRI was negative. (Px9). Dr. Petkovich reviewed the right hip MRI as well as the CT/myelogram films on 2/22/14. His review of the myelogram and CT indicated mild bulges at L3/4 and L4/5 with no evidence of herniation of nerve impingement, and good structural alignment at L5/S1. Based on this review, he determined that Petitioner had reached MMI and was able to return to his regular job on an unrestricted basis. (Rx2).

A significant delay ensued at this point while Respondent was determining if surgery would be approved. After approval, at a 4/7/14 pre-op visit, Petitioner reported his right leg pain was greater than his back pain. Dr. Heffner noted that surgery may not relieve his leg pain as he'd had symptoms for two years at that point. (Px9). 4/7/14 lumbar x-rays were reported to show partial sacralization of L5 with a vestigial disc space at L5/S1, and the disc spaces appeared relatively well preserved. (Px6). The right L3/4 laminectomy and discectomy was performed on 4/16/14. The report noted a sizeable central and right sided disc protrusion, which was entered to remove fragments. There was no specific indication as to whether nerve compression was found or to what degree. (Px9). On 4/16/14 a repeat CT/myelogram was performed, which notes the sacralized L5 level and that the surgery had actually been performed at L3/4. The report also noted rudimentary ribs or unfused transverse processes at the thoracolumbar junction. (Px6). In a phone call to Dr. Heffner's office on 4/23/14, Petitioner reported he was doing much better with no right leg pain, though the leg remained weak. (Px9).

Interestingly, a 4/30/14 note from Sparta Community Hospital noted the Petitioner had been involved in a motor vehicle accident, and complained of low back and right leg pain. (Px3). On 5/12/14 Petitioner's wife called to report onset of right heel and ankle pain, which Dr. Heffner indicated would not be related to the L3/4 level, and that was improved a week later. Therapy was prescribed on 5/19/14. On 5/22/14, Petitioner reported dramatic improvement versus prior to surgery, with normal gait and no neurological symptoms in the right leg. (Px9).

Dr. Heffner's records note what appears to be a 6/30/14 nurse's note indicating Petitioner had occasional low back pain. Dr. Heffner's 6/30/14 report notes he had made excellent progress with no significant radicular pain, and he was advised to complete the last three weeks of therapy "and then he can be released to full duty without restrictions at maximum medical improvement", as of 7/21/14. (Px9).

The next note from Dr. Heffner is a 10/8/14 phone call from Petitioner's wife reporting right ankle and knee swelling and pain, and she was advised that Petitioner should see his primary care provider for this. On 11/25/14, Mrs. Roady called and reported Petitioner had a three week history of low back pain with no known cause, noting Petitioner had not found a job. On 12/4/14, Dr. Heffner's report states: "He did not feel that he is doing well with work, however, and has had some component of back pain. Generally, this has been tolerable until about the last six weeks." He had pain in the right SI joint with no radiation or weakness. Therapy and SI joint injections were prescribed, noting that since Petitioner was unable to do his job, an FCE would be obtained to determine if any permanent restrictions are needed. Dr. Heffner did not believe the current symptoms were coming from the lumbar spine. (Px9).

There again appears to have been a delay in approval until Petitioner saw Dr. Du with pain management on 4/3/15. Petitioner reported pain in the right hip starting with a 4/16/12 work injury, and that the 2014 discectomy did help his right leg pain, but it since had "relapsed". He reported 3/10 to 8/10 low back and right buttock pain. Petitioner reported that just about any activity or position caused pain, and that conservative treatment had helped him somewhat. Dr. Du diagnosed right SI joint dysfunction and pain, post L3/4 surgery syndrome and chronic lower back pain. Dr. Heffner was recommending a right SI joint injection, which was performed. Petitioner reported improvement and this procedure was repeated on 4/17/15.The diagnosis added SI joint degenerative disease. (Px7).

Dr. Heffner's records indicate Petitioner was a no show for a 4/7/15 visit, and canceled a 4/27/15 visit due to the flu.

The Petitioner attended therapy. The Arbitrator notes these records generally indicate the Petitioner reports increased strength but no real change in his pain complaints. He noted that he was now able to put weight on the

right leg. It should also be noted on 4/16/15 the Petitioner indicated he had been mushroom hunting all day, and on 4/29/15 had been fishing and it was hard to ride in the boat. (Px3).

The FCE was performed on 6/10/15 at Sparta Community Hospital. The report indicates Petitioner appeared to give valid and consistent effort, and determined he was at the heavy physical demand level, but "per (Petitioner's) report", this did not meet his job demands. The report also noted he had a minimal antalgic gait during testing until late in the activity circuits, and post testing he displayed minimal right antalgia. (Px3; Px9).

It appears Petitioner last saw Dr. Heffner on 7/20/15. Noting the delay in getting authorization, Dr. Heffner reported that Petitioner indicated SI joint injection didn't provide lasting benefit and that therapy helped but did not solve the problem. Petitioner's pain was not radicular down the leg or in the midline back, it was in the right SI joint. Noting the FCE indicated Petitioner could lift 30 pounds and lift 20 pounds overhead, "we can make these restrictions permanent but from the standpoint of his lumbar spine and his lumbar surgery, he does not require any additional treatment and can be released from my care." Noting Petitioner was unable to return to full duty work due to the SI joint pain, Heffner referred Petitioner to physical medicine specialist Dr. Ermis, and released him at MMI from a neurosurgical standpoint. (Px9).

Petitioner's last therapy visit was on 10/5/15, at which time he indicated his pain was relatively unchanged after 24 visits. Several of these notes indicate the Petitioner was using a push mower to cut grass. (Px3). At Vigilant Anesthesis Care and Pain Management on 10/9/15, Dr. Randle noted complaints of right hip lumbar pain. Lyrica and a Butrans patch were prescribed. (Px10).

An 11/23/15 note from Convenient Care indicated Petitioner advised he wanted to be referred to either Dr. Coyle or Dr. Gornet. (Px2).

At the initial visit with Dr. Gornet, Petitioner reported right-sided pain in the low back to the right buttock and hip, and paresthesias down the right leg. Petitioner reported the surgery with Dr. Heffner helped his leg pain, but he had continued low back/buttock/hip pain that was worse with prolonged stand/sit/bend/lifting, and Petitioner did not feel he would be able to work with the 30 pound restriction of Dr. Heffner. Neurological exam was normal, and there was no sign of instability in flexion/extension x-rays. Dr. Gornet noted the 7/30/13 MRI report indicated a central protrusion with annular tear at the first open lumbar segment, and a right paramedian disc at the second open segment, which was Dr. Heffner's operative level. Dr. Gornet indicated it was clear Petitioner's problem was not a back strain or the SI joint, as his symptoms were consistent with an L4/5 disc. He noted the sacralized L5/S1 segment "would easily" place increasing stress on adjacent segments, and that the prior surgery did not address the structural problem. He requested an updated MRI, noting he believed Petitioner's L4/5 disc and the current symptoms are related to the 4/16/12 accident. (Px11).

Dr. Gornet on 5/16/16 noted he reviewed the 8/23/12 and 7/30/13 MRIs, and notes both that the initial MRI showed a slightly larger L3/4 disc, but that the latter films showed that this disc had progressed. He noted Petitioner's choices are permanent restrictions versus disc replacement surgery (L3/4) with fusion (L4/5). As Petitioner emphatically indicated he could not live with his current condition, Dr. Gornet prescribed "VMA motion analysis" and "MRI spectroscopy" in preparation for surgery. (Px11).

A 5/16/16 repeat lumbar MRI noted: 1) presumed post-op changes at L3/4 with enhancing scar in the ventral epidural space without recurrent herniation or stenosis, 2) abnormal disc profile at L4/5 with annular fissure creating concavity of the dura ("While there is some enhancement, this does not fully enhance this abnormality which is suggestive of a small disc herniation"), with mild bilateral stenosis and no canal stenosis, and 3) rudimentary L5/S1 disc. (Rx4). The 7/7/16 lumbar MRI report of Dr. Cizek is extremely limited in explanation,

noting nothing other than small central protrusions at L3/4 and L4/5. This may be the spectroscopy. (Px12; Rx4). On 8/18/16, Dr. Gornet notes MRI spectroscopy showed painful discs at L3/4 and L4/5, and VMA motion analysis showed no contraindication to his plan. (Px11).

On 7/28/16, Petitioner was examined at the Respondent's request by Dr. Stiehl pursuant to Section 12 of the Act. Following a review of the prior medical an examination of Petitioner, Dr. Stiehl opined that the Petitioner has mechanical back pain. He noted no evidence whatsoever of radiculopathy. He indicated Petitioner had been treated for a right L3/4 disc, but that the records indicated a normal EMG/NCV and no evidence per MRI of foraminal encroachment or motion segment integrity at the time of the surgery. Given Petitioner had only "low grade" back pain, no radicular symptoms and no evidence of lumbar spine instablility, Dr. Stiehl opined there was no indication for surgery and advised he would not support Dr. Gornet's request for same. (Rx3).

On 11/17/16, Dr. Gornet reviewed the report of Dr. Stiehl, noting they agree that Petitioner has mechanical low back pain, but that a lack of radicular/neurological findings are not a contraindication to the recommended surgery. Dr. Gornet also noted he did not find any significant Waddell signs during his exam. (Px11).

Dr. Gornet testified via deposition on 2/27/17. He testified that MRI films from 8/23/12 showed problems at both L3/4 and L4/5 prior to the surgery performed by Dr. Heffner. The Heffner surgery had alleviated at least a significant part of Petitioner's right leg pain, and Dr. Gornet agreed that his exam did not reflect any focal neurological abnormalities. However, he opined that the discectomy surgery, per the literature, weakens the spine by approximately 30%. Thus, he noted the Petitioner had this weakening along with the fact that no treatment had yet been directed to the unoperated abnormal disc. The recommended surgery, either two level disc replacement or one level disc replacement with fusion of the other level, would be performed anteriorly to address the structural problem in the lumbar spine. He testified that in his experience 80% of patients return to unrestricted work following such surgery. Without surgery, Petitioner is "rapidly heading toward either more stringent restrictions or being off work if his level of symptoms continued to be a problem for him." (Px11).

Asked about the opinions of Dr. Stiehl, Dr. Gornet testified he believed his office had more "complete" experience with these conditions, that Petitioner has clear disc pathology and a prior surgery, and that the medical literature has many reports of patients who need further treatment after surgical decompression due to the destabilizing effect. (Px11).

On cross examination, Dr. Gornet explained that the initial MRI and records in this case indicating pathology at L4/5 and L5/S1 actually referred to the L3/4 and L4/5 levels, as the L5/S1 disc was sacralized, so there was no discrepancy as to the same discs being involved from the beginning. Dr. Gornet testified that he couldn't state with certainty if it was true that no other doctor involved in the case has recommended a second surgery. He didn't order an updated EMG because Petitioner had a normal neurological exam, and Petitioner stated that surgery improved his leg pain, though he agreed Petitioner reported some paresthesias down the right leg. Dr. Gornet disagreed that back pain without a radicular component cannot be resolved via surgery, indicating this is supported by current science. He testified that decompression can address enough of a back problem that the patient can deal with the increased destabilization of a decompression, especially if they have a sedentary job, but if the job involves mechanical loading of the back "you may find that you become increasingly symptomatic". He opined that Dr. Heffner's surgery was appropriate and Petitioner could have done well afterwards, but there was an annular tear below the surgical level that was not treated and remains an issue which Gornet believed plays a role in his current symptoms. Dr. Gornet saw no signs of symptom magnification with Petitioner.

CONCLUSIONS OF LAW

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

Based on the evidence presented, the preponderance of same supports the finding that the Petitioner's current lumbar condition remains causally related to the 4/16/12 accident. The Arbitrator notes some degree of pause given the Petitioner reported jumping or falling from a roof in 2011, which clearly would have a more forceful impact on one's spine, however there was no evidence presented which shows the Petitioner had any ongoing low back symptoms or treatment that continued to the time of the accident at issue here. There was no dispute that an accident occurred in this case. Arguably the Petitioner could be found to no longer have a causal relationship to the accident following Dr. Heffner's 7/21/14 release at MMI. However, the Petitioner testified he attempted to work at that time in or around August 2014, had difficulty doing so, and he returned to Dr. Heffner indicating he again developed back pain in late October/early November 2014.

The evidence supports that the Petitioner has had ongoing subjective complaints that have remained significantly consistent since the beginning of this case. The Arbitrator finds that the Petitioner has sustained his burden of proof that his condition remains causally related to the 4/16/12 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:

With respect to disputed issue (J), the Arbitrator concludes all the medical treatment provided to Petitioner for his injury was reasonable and necessary and Respondent is responsible for the medical bills incurred as a result thereof. Consistent with his liability determination, the Arbitrator awards Petitioner the medical expenses contained in Px13 related to treatment for Petitioner's injury.

Respondent is to pay the medical bills identified in Px13 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule, including reimbursement to Petitioner for any out-of-pocket expenses, if any, he incurred. Respondent shall be given a credit for any amounts already paid towards the awarded medical expenses.

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

The Arbitrator finds that the Petitioner has failed to prove the reasonableness and necessity of the surgery proposed by Dr. Gornet.

Dr. Heffner, who performed the original discectomy surgery, indicated he believed that Petitioner's complaints following the July 2014 post-surgical release relate to the right SI joint and referred the Petitioner to Dr. Du for pain management. Dr. Gornet subsequently opined in 2015 that he believed the Petitioner's symptom were referred pain from the lumbar spine due to destabilization. Dr. Stiehl essentially indicated that there was no evidence of spinal instability, low grade back pain and no indication for lumbar surgery. The evidence in this case simply does not clarify what is causing the Petitioner's ongoing complaints.

While Dr. Gornet indicates that there is pathology at L4/5 that is clearly causing Petitioner's symptoms, no other surgeon involved in this case has recommended surgery for Petitioner. Dr. Heffner ultimately perform discectomy surgery based mainly on his findings on the initial CT/myelogram. While Petitioner has reported that the surgery resolved his right leg pain, the subsequent records, in the Arbitrator's view, do not bear this out. It is unclear to the Arbitrator that the surgery really did much at all to resolve his symptoms other than on a temporary basis. Drs. Chabot and Petkovich did not recommend surgery. The Arbitrator believes that the atrophy noted by Dr. Petkovich supports that something was going on with Petitioner that resulted in the atrophy, and thus that the original surgery was reasonable.

That said, again, it does not appear that the surgery really did much of anything with regard to Petitioner's subjective complaints. The Arbitrator notes that there are some issues with regard to the credibility of Petitioner's subjective complaints. There is evidence that the Petitioner has had issues with anxiety and depression going back to at least May 2012, which potentially could impact his subjective complaints. The Petitioner has reported to physicians that he has not worked since the date of accident, but Dr. Chabot indicated he reported he worked at Spartan Light Metals after the Respondent terminated him. Dr. Chabot indicated what he felt was evidence of symptom magnification, and it appears he chose to see this physician as opposed to it being a Section 12 exam. The Petitioner reports tingling and a "bug feeling" in his right leg and foot, but all of the surgeons including Dr. Gornet indicate there is no evidence of neurological deficits on exam. The Petitioner reported the surgery resolved much of his leg pain, but then indicates he continues to limp. At the same time, there are therapy records from 2015 which indicate he was mushroom hunting all day, mowing the lawn with a push mower on multiple occasions and going fishing. Yet, the medical records reflect his subjective pain increases with virtually any activity. The FCE indicated Petitioner was capable of working at the heavy demand level, but Petitioner indicated that this exceeded his regular job duties. There really is no evidence in this case which would allow the Arbitrator to determine if that is or is not true, as he did not discuss what his regular job entailed outside of what he was doing at the time of the accident. He does report having to lift sand all day, but there is no detail as to how or what weights he had to deal with.

Ultimately, it appears to the Arbitrator that Dr. Gornet's surgical recommendation is significantly based on the Petitioner's subjective complaints, and it is unclear to the Arbitrator how truly connected the subjective complaints are to the objective lumbar pathology. Additionally, as noted, the original surgeon has indicated his belief that it is an SI joint problem. At the same time, it certainly appears that there are developmental issues in the Petitioner's spine at both the thoracolumbar (see the 4/16/14 a repeat CT/myelogram, Px6). and lumbosacral areas (sacralized L5/S1).

At one point Dr. Gornet testified that the sacralized L5/S1 segment increases the stress at adjacent segments over time (Px14, p. 11), then testified that there was no indication that this congenital condition caused any problems over the long term in the absence of trauma. These appear to be inconsistent statements in the Arbitrator's view. The Arbitrator also questions Dr. Gornet's utilization of "MRI spectroscopy" and "VMA motion analysis", as these tests are not utilized, in the Arbitrator's experience, by other spinal surgeons in the Petitioner's geographic area. Additionally, it appears to the Arbitrator that Dr. Gornet has not taken into consideration any of the noted questions the Arbitrator states here with regard to the Petitioner's credibility level.

Finally, the Arbitrator notes that the films themselves, to date, other than the nerve compression noted by Dr. Heffner per the initial CT/myelogram, do not provide any significant findings of spinal instability.

Dr. Gornet has proposed a significant and serious surgery, and the Arbitrator finds the preponderance of the evidence does not support the reasonableness and necessity of the surgery. As such, the Arbitrator declines to award the requested prospective medical.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The parties indicated at hearing that the Petitioner is claiming all TTD applicable to this claim (7/26/13 to 6/30/14 and 12/4/14 to 4/25/17), and stipulated that Respondent is entitled to a $47,844.98 TTD credit. The Arbitrator finds that the evidence supports the finding that the Petitioner is entitled to this claimed period of TTD, and the Respondent is entitled to the stipulated credit.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES VANDERPLOEG,

Petitioner,

18IWCC0169

vs.

NO: 10 WC 10472

RAG'S ELECTRIC,

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 employment, accident, causation, notice, medical expenses, average weekly wage/benefit rate, temporary total disability, permanent partial disability, and wage differential, 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.

Findings of Fact & Conclusions of Law

1. Petitioner testified that from February 2009 until the end of December 2009, he was employed by Respondent as an electrician. He performed a wide variety of activities for Respondent, including conduit piping, pulling wire, using drills, and "doing light poles." Erecting the light poles required overhead work. The poles weighed a "minimum of couple of hundred pounds." He used hammers and drills in that employment. They call the drills he used "whole hogs;" "they're basically big 20 or so pound drills that [are used] to make homes for conduit" as well as "hammer drills." He would drill in both wood and concrete, but more often in wood. Most of the time he would be drilling overhead "making holes for the concrete" in boards.

2. Petitioner noticed pain in his right shoulder when using those drills, especially when drilling in concrete or when hitting a nail when drilling in wood. "The vibration and everything was causing issues with" his shoulder. Hitting a nail would "Basically stop the drill from drilling and put all the torque on" his shoulder. He held the drills in his right hand. He also used hammers for a lot of different things, but that activity was not overhead. He would also have to bend conduit using a "bender" of different sizes depending on the size of the pipes. "The bender machines themselves are probably around 100 pounds with the hand benders being smaller." He would have to carry the benders, but with help. Anything done overhead, including installing conduit, caused pain and less functionality in his shoulder.

3. Petitioner testified he started having issues with his shoulder "towards the beginning of" his employment. After a couple of "projects of doing light poles, you know, using the jackhammers, using the overhead drills" he had less mobility in his shoulder. His job was union and at the end of his employment his job title was journeyman electrician. He was hired as a foreman so he had some supervisory role as well. Petitioner explained how he would use a long flexible wire to pull conduit through the length of the conduit, which "could be a couple of feet, could be a couple hundred." He pulled the wire down most of the time. He also installed ceiling fans, which required overhead work.

4. Petitioner also used mostly hacksaws but also used Sawzall saws in his work. He used them to cut conduit to the proper length. The "repetitive motion" using the saws "definitely aggravated" his shoulder. Prior to his work with Respondent, Petitioner worked between four and five years for S & H Electric. He started there as an apprentice and worked his up to be journeyman. There, he was qualified only to perform residential work; he started doing commercial work working for Respondent. Petitioner was laid off at the end of 2009 because there was "not enough work at the moment."

5. Throughout 2009, he was losing more mobility and was having a lot more pain in his shoulder. Petitioner first sought medical treatment for his shoulder on February 1, 2010. Petitioner acknowledged that he had a previous shoulder injury in 1998 playing football. He had shoulder surgery on November 18, 1998 with Dr. LaBelle. He also had another incidence of shoulder pain in 2006. He returned to Dr. LaBelle, who treated him from March 2006 through April 2006. Petitioner returned to work at full duty on April 17, 2006. He had no prescription medication, physical therapy, or injections during that treatment in 2006. He had no treatment between April 17, 2006 and February 1, 2010.

6. Petitioner eventually saw Dr. Marra on April 13, 2010; he ordered a CT. Thereafter, Dr. Marra performed arthroscopic surgery on August 16, 2010. Dr. Marra indicated that the condition was worse than he anticipated and that a second, non-arthroscopic, surgery was necessary. He performed the second surgery on August 25, 2010. He had a Functional Capacity Evaluation ("FCE") on January 9, 2012. The delay was caused by Respondent's denial of authorization. Dr. Marra released him to work with permanent restrictions on February 23, 2012, including maximum lifting of 16.5 and carrying of 10 pounds.

7. Petitioner met with a vocational rehabilitation counselor on April 30, 2012. Following his layoff and subsequent medical treatment, Petitioner was unemployed from February 5, 2010 to July 5, 2012. After his FCE, he looked for work within his restrictions. He did not keep any records of his job search. He ultimately found alternate employment as delivery coordinator for a VW car dealership in Schaumburg. He initially earned $9 an hour but was learning to become a salesman. After about six to eight months he became a salesman. He earned somewhere between $150 and $200 a week, plus commission and bonuses for cars sold.

8. Petitioner left the Schaumburg dealership and went to work for another VW dealership in Joliet, because it was half of the commute time. He was hired there as internet sales manager. He received a $1,000 signing bonus at Joliet and his salary there is $500 a week, plus commissions and bonuses. The current union wage in his previous job was $49.25 an hour. Petitioner was no longer a member of the union; he left in the summer after his injury because he knew he would no longer work as an electrician.

9. Petitioner testified that currently, he cannot work as an electrician, cannot "do anything over" his head, cannot throw, and does not have the range of motion to do anything with his shoulder. He does not use his right arm to do any work in his current job, except with a pen. He occasionally takes over-the-counter medication, "when the pain is higher than usual." He does exercises "to keep it from seizing up." He was told he will need shoulder replacement, and it would come sooner if it seized up. Pain in his shoulder wakes him when he sleeps, especially when he rolls over on it.

10. On cross examination, Petitioner testified his shoulder dislocated both before and after his 1998 injury. He acknowledged that Dr. LaBelle's note from February 1, 2010 indicated he had about 20 dislocations before his surgery. The surgery involved arthroscopic repair of the labrum and installation of hardware. After the 1998 surgery, his shoulder felt a lot better and he had full use of it.

11. Petitioner agreed that he saw Dr. LaBelle in August 2004 because his shoulder was sore. Dr. LaBelle recommended rest, but did not prescribe anything else. When he saw Dr. LaBelle on February 1, 2010, he did not recall telling him that his shoulder felt good for about five years after the 1998 surgery. He also did not recall on February 5, 2010 telling Dr. Bare that he had shoulder pain for the previous 10 years.

12. Richard Grant was called to testify by Respondent. He retired on March 14, 2014. He worked for Respondent from May 2004 to his retirement, at which time he was "general foreman, owner in fact." Respondent did residential, commercial, and street lighting. Petitioner was employed by Respondent as an electrician in early 2009.

13. Petitioner's job was to do service calls and any little jobs they had that required an electrician, "whether it be hang a ceiling fan or run a new circuit." Less than 1% of Petitioner's work with Respondent involved light poles and almost all of that was with the use of a crane or other assisting machine. The light poles are 30' tall, 4' in circumference, and weighed about 600 lbs. "It's just impossible" to physically stand a

30-foot pole by hand. 99% of the time, pipes would be bent with a hand bender, which weighed 5 or 15 pounds.

14. In January 2010, he received notice that Petitioner applied for unemployment insurance benefits. It was around February 24, that he received notice that Petitioner filed the instant claim. He was informed about the claim by Petitioner's father, who had been a business associate of the witness. An objection to a question of what Petitioner's father told him about why Petitioner filed the claim was sustained. Respondent's lawyer presented an offer of proof indicting that Mr. Grant would testify that Petitioner's lawyer advised him that he had to file his claim against his last employer. Mr. Grant was aware that Petitioner worked as an electrician before he was hired by Respondent.

15. On cross examination, Mr. Grant testified that he is a union electrician. During his ownership of Respondent from 2004 through 2014, he performed the physical work of an electrician on the job sites. He thought Petitioner's testimony about his work involving conduit was accurate. He agreed that it was fair to say that when the witness worked as an electrician, a "vast amount" of his work was over shoulder level, depending on the job involved. He used hammers, and drills, but not jackhammers. He agreed that the drill weighted about 20 pounds and it caused torque on his upper body when it got stuck in a hole. He called the union and specifically asked for Petitioner, as a favor to his father.

16. The medical records reveal that on October 9, 1998, Petitioner had MRI that showed a large effusion, a 4 x 2 mm loose body, posterior subluxation of the humeral head in relation to the glenoid, an impaction fracture in the humeral head, and labral abnormality consistent with a tear. There is also a handwritten notation that "CT – very abnormal. Get in to see Dr. (illegible) *et al* ASAP."

17. On November 17, 1998, Petitioner presented to Dr. LaBelle the day before scheduled surgery. He reported he hurt his right shoulder several years earlier playing football. He felt his shoulder pop in and back in at that time. He has not been able to throw since because of the shoulder felt unstable. Most recently it popped out on September 20, 1998 and he had recurring pain. "Since then it has been popping out on a daily basis but to a lesser extent." Dr. LaBelle diagnosed multidirectional and recurrent anterior dislocation and subluxation.

18. The next day, Dr. LaBelle performed right shoulder capsular shift for multidirectional instability, extensive anterior and posterior Bankart repairs of labral tears, and arthroscopic debridement of chondral defects, for multidirectional instability, anterior and posterior labral tears, anterior dislocation, and osteoarthritis. The arthritis was a postoperative diagnosis.

19. On February 1, 2010, Petitioner returned to Dr. LaBelle reporting that his right shoulder pain had progressed over the past few years. He had labral repair surgery in 1998 after recurrent, about 20, dislocations. Dr. LaBelle's operative findings at surgery showed significant arthritis, with full-thickness cartilage loss at the posterior glenoid rim and near full-thickness cartilage loss in the central aspect of the glenoid.

20. Dr. LaBelle noted that current x-rays also found degenerative joint disease. Petitioner was doing well postoperatively until he noticed increased pain and reduced range of motion five years earlier. He worked as an electrician and was getting limited in his ability to reach. X-rays showed significant degenerative changes. Dr. LaBelle referred Petitioner to Dr. Bare.

21. On February 5, 2010, Petitioner presented to Dr. Bare. He reported right-shoulder pain over the past 10 years or so and he also had reduced range of motion. Dr. Bare noted that the x-rays from 2/1 showed advanced degenerative osteoarthritis. Dr. Bare indicated that Petitioner's arthritis had progressed to a stage that it affected his activities of daily living. He also noted that such arthritis in a young patient posed clinical challenges. They discussed treatment options, including surgery to resurface the glenoid, and revision 10 to 15 years thereafter. Dr. Bare did not believe that simply removing the prominent anchors would provide much relief in pain and improved range of motion due to the severity of the arthritis. Petitioner would consider his options. If he wanted to proceed with surgery. Dr. Bare would recommend a preop CT.

22. On April 13, 2010, Petitioner presented to Dr. Marra for evaluation of progressive pain and loss of functionality on his shoulders. He had "arthroscopic instability surgery in 1998." X-rays showed end-stage arthritis. Dr. Marra recommended a CT, which showed moderate glenohumeral osteoarthritis with mild bony remodeling and relative exaggeration of glenoid retroversion compared to the scapular blade and exposure of one of three suture anchors through the cortex face. Dr. Marra thought the CT indicated one of the anchors in the anterior glenoid might be prominent. Dr. Marra recommended a diagnostic arthroscope, even though he thought success was uncertain due to the extensive nature of the arthritis.

23. On August 16, 2010, Dr. Marra performed extensive debridement of the right shoulder for osteoarthritis and retained metallic suture anchor. He noted in the operative report that an open procedure would be necessary to remove the hardware.

24. On June 16, 2010, Dr. Marra responded to an inquiry from Petitioner's lawyer. He noted Petitioner had clear evidence of end-stage osteoarthritis when he saw him on April 13. A CT showed prominence of a metallic suture. "Clearly heavy activity with a prominent suture anchor would be a clear and competent cause of his arthritis at his age."

25. On August 25, 2010, Dr. Marra performed posterior arthrotomy with impaction of the suture anchor for retained metallic structure in the glenohumeral joint.

26. Dr. Marra testified by deposition on January 17, 2011. During surgery, he discovered that Petitioner had end-stage arthritis and the cartilage was "completely gone." He also noted the prominent anchor. He tried to either remove it "or pound in the anchor deeper below the level of the bone" but he was not able to.

27. Dr. Marra concluded an open procedure would be necessary. He performed the open surgery, arthrotomy, on August 25, 2010. Initially, he tried to unscrew the anchor, but it was stripped. Therefore, he drove it deeper below the joint surface.

28. During his treatment of Petitioner, Dr. Marra became aware of his work activities. He believed Petitioner was "working overhead, pulling wires, that type of stuff." He was using tools at chest level and overhead. Dr. Marra understood that Petitioner had surgery in 1998 after recurrent dislocations. Basically, the ligaments of the shoulder were repaired with anchors. Dr. Marra opined that Petitioner's work activities aggravated or accelerated his right-shoulder condition requiring treatment, including his surgeries. He thought the repetitive overhead work to be a heavy use of the shoulder and the prominent anchor was significant. He has not released Petitioner to work as an electrician. Dr. Marra opined that Petitioner's inability to work resulted from arthritis caused by his work activities.

29. On cross examination, Dr. Marra testified he did not know when Petitioner last worked, or how long he worked for Respondent. End-stage arthritis involves the absence of cartilage and bone-on-bone contact. He did not think he reviewed any previous medical records, except the prior x-rays.

30. At Respondent's request, on February 17, 2011 Dr. Suchy performed an examination on Petitioner pursuant to Section 12 of the Act and reviewed medical records. Petitioner played running back for Naperville High School and had multiple injuries to his shoulder playing football in 1997 with multiple subluxations. He dislocated his shoulder in 1998 and had arthroscopic labral surgical repair. Petitioner reported he did well until about three years earlier and had gradually worsened since then. He had surgery with Dr. Marra on July 13, 2010 and was not currently working.

31. Dr. Suchy noted that the x-rays taken prior to Dr. Marra's surgery showed end-stage arthritis. He also noted that Dr. Marra's arthroscopic operative report indicated there was significant arthritis in the shoulder, with retained metallic anchor suture, objective extensive arthritic changes with diffuse synovitis, lack of cartilage in the inferior quadrant of the glenoid. Dr. Marra was unable to remove or flush the anchor, abandoned the arthroscopy, and performed an open procedure on a later date.

32. Dr. Suchy opined that there was no causal relationship between Petitioner's end-stage arthritis and his work as an electrician, but rather it stemmed from his multiple injuries as a high school football player. It was documented in the CT and Dr. Marra's operative report that one of the metallic anchors was prominent and "appeared to have been wearing away the articular cartilage of the humerus. Therefore, the development of end-stage osteoarthritis of the right shoulder is not secondary to his employment as an electrician but would have occurred with his normal daily activities of living." Work should be restricted to 10-pound lifting with no activities above the shoulder with the right arm. All treatment administered to date was appropriate but not related to his work activities. In addition, he would likely need a shoulder replacement in the near future.

33. On May 11, 2010, Dr. Marra issued another response to another inquiry by Petitioner's lawyer, Dr. Marra reiterated that Petitioner's repetitive motion as an electrician "could have contributed to the arthritis present in his shoulder." He reviewed the Section 12 medical examination report of Dr. Suchy. Dr. Marra noted he was not aware of any significant traumatic events in Petitioner's past, "but clearly a prominent suture anchor and subsequent motion is a competent cause of the findings present in his shoulder."

The Arbitrator denied compensation. The Commission agrees with that conclusion. However, we believe it is necessary to further clarify the bases for such denial. First, the Arbitrator found that there was no employment relationship because Petitioner acknowledged that he was laid off prior to his reported manifestation date of February 1, 2010. The Commission finds that determination was erroneous.

In *A.C. & S v I.C.C.*, 304 Ill. App. 3d 875 (1st Dist. IC Div. 1999), the Appellate Court reversed the Circuit Court and affirmed the decision of the Commission awarding compensation. The Appellate Court rejected the employer's argument, adopted by the Circuit Court there and the Arbitrator here, that a repetitive-trauma injury is not in the course of employment if the manifestation date is after the claimant was terminated for non-health related reasons. The Appellate Court held that "the modern rule allows compensation even when an injury occurs at a time and place remote from employment if its cause is something that occurs entirely within the time and place of employment." Therefore, the Commission finds there was an employment relationship at the time of the alleged manifestation of Petitioner's condition of ill-being and vacates that portion of the Decision of the Arbitrator.

While the Commission disagrees with the determination of the Arbitrator that there was no employment relationship between the parties at the time of the alleged manifestation, the Commission agrees with the Arbitrator's finding that Petitioner did not sustain his burden of proving accident and/or causation to his current condition of ill-being. The Arbitrator noted "there was no evidence to support petitioner sustained injuries to his right shoulder as a result of an accident (repetitive or otherwise) on February 1, 2010, or on any date, that arose out of and it the course of his employment with respondent." The Commission also finds relevant that Petitioner did not seek treatment until more than a month after he was laid off and after his last day of employment with Respondent. The delay in treatment militates against any acute work-related injury, or even an acute inability to work based on accumulated injury from repetitive trauma.

On the issue of causation, the Arbitrator noted that the records of Dr. LaBelle and Dr. Bare indicate that Petitioner reported increasing pain in his shoulder for several years prior to the alleged manifestation date, Petitioner did not associate his condition to his work activities to Dr. LaBelle or Dr. Bare, and Dr. Marra's causation opinion was unpersuasive because he was unaware of Petitioner's specific work activities or the duration of his employment with Respondent. She attributed Petitioner's current right-shoulder condition to his football injuries in high school.

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The Arbitrator was correct about his long-standing severe arthritic condition prior to alleged accident and he did report that his condition had been worsening for some years prior to the alleged manifestation date. In addition, on the issue of causation, the Commission finds the opinion testimony of Dr. Suchy more persuasive than that of Dr. Marra. Not only was Dr. Marra uninformed about Petitioner's exact work activities, his causation opinion is not really unequivocal. He notes that the prominence of the anchor is significant. He also stated that Petitioner's repetitive overhead activities constituted heavy use of the shoulder and that with the prominent anchor could be competent cause of Petitioner's arthritis. However, Dr. Marra never opined that his work as carpenter in any way was related to the prominence of the anchor, which was at least partially responsible for the surgeries Dr. Marra performed. Dr. Marra also acknowledged that Petitioner had end-stage, bone-on-bone arthritis when he first saw him.

Rather, the Commission is more persuaded by the causation opinion of Dr. Suchy, who noted that Petitioner's underlying arthritis was at such a stage that any activity of daily living would aggravate it, cause symptoms, and eventually require surgery. Therefore, the Commission finds that Petitioner's current condition of ill-being was caused by the natural progression of his pre-existing arthritis and not any work activities while working for Respondent. Therefore, the Commission denies compensation.

IT IS THEREFORE ORDERED BY THE COMMISSION the Arbitrator's denial of compensation in this matter is hereby affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION Petitioner has failed to sustain his burden of proving he sustain a work-related accident while employed by Respondent or that the condition of his ill-being of his shoulder was causally related to his work activities.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given credit for the $16,636.77 for payment of temporary total disability benefits.

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

DATED: MAR 19 2018

Kevin W. Lamborn

David L. Gore

Stephen J. Mathis

KWL/dw
O-1/25/18
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0169

VANDERPLOEG, JAMES B
Employee/Petitioner

Case# 10WC010472

RAG'S ELECTRIC
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:

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

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

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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

James B. Vanderploeg
Employee/Petitioner

v.

Rag's Electric
Employer/Respondent

Case # **10** WC **10472**

An *Application for Adjustment 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 of **New Lenox**, on **May 2, 2016 and August 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. X Was there an employee-employer relationship?
C. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. X What temporary benefits are in dispute?
☐ TPD ☐ Maintenance X TTD
L. X What is the nature and extent of the injury?
M. X Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. X Other **is petitioner entitled to a wage differential?**

FINDINGS

On **February 1, 2010,** Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner earned **$64,918.36**; the average weekly wage was **$1,248.43**.

On the date of accident, Petitioner was **30** years of age, **single** with **1** dependent children.

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

Respondent ***has paid*** for all appropriate charges for all reasonable and necessary medical services for which they are liable.

To date, Respondent has paid $ **0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

Respondent shall be given a credit of $ **15,636.77** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$15,636.77.**

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

ORDER

Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with respondent on February 1, 2010, or at any time.

Respondent shall be given credit for the $15,636.77 TTD benefits paid.

Petitioner's claim is hereby denied and case is dismissed.

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

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

Christine McCoy

Signature of Arbitrator

04/06/2017

Date

APR 11 2017

18IWCC0169

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Vanderploeg	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 10 WC 10472**
	)	
Rag's Electric	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter was heard in New Lenox on May 4, 2016 and August 4, 2016. The parties agree that on February 1, 2010 petitioner and respondent were operating under the provisions of the Illinois Workers' Compensation Act. They agree petitioner gave respondent notice of the claimed accident within the time limits stated in the Act. The parties agree that in the year predating the claimed accident, petitioner earned $64,918.36 and his average weekly wage was $1,248.43.

At issue in this hearing is as follows:

1. Whether there was an employee-employer relationship between petitioner and respondent at the time of the claimed accidental injury to petitioner's right shoulder.
2. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment with respondent;
3. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
4. Whether respondent is liable for the unpaid medical bills totaling $4,673.82
5. Whether petitioner is due TTD from February 1, 2010 through February 23, 2012.
6. What is the nature and extent of injury including whether petitioner is entitled to a wage differential?
7. Whether petitioner is entitled to penalties and attorney's fees.

STATEMENT OF FACTS

Petitioner's Testimony

Petitioner testified he was employed by respondent as an electrician from February, 2009, until the end of December 2009. As such, petitioner performed a variety of different tasks that included conduit piping, pulling wires and drilling. He also worked on light poles, that weighed a couple of hundred pounds. The light poles were erected or fixed. This called for him to perform overhead work.

He also used "whole hog" drills that weighed approximately twenty pounds, as well as hammer drills which he used to drill into concrete and brick. He often was required to drill overhead into two-by-fours for the conduit to go through. Petitioner noticed that when he drilled

his right shoulder would hurt, especially if he hit a nail in the wood. He also used a hammer for many different things.

Petitioner would also use a bender to bend conduit, which is the pipe that contained the electrical wires. The benders could be small hand-held benders and others that weighed up to 100 pounds. Petitioner was required to carry the benders and set them up.

Petitioner noticed pain in his right shoulder shortly after he started working for respondent. After a couple of projects putting up the light poles, using jack hammers and using drills overhead, he loss mobility.

Petitioner was journeyman electrician which he had been for three or four years. This job including using a fish tape to pull flexible wire through conduit. He also worked on ceiling fans. He also used hand held hacksaws.

Petitioner obtained an A-card with the union before he was employed by respondent. As such, he was a journeyman foreman; allowing him to work as a supervisor.

Petitioner was on an apprentice program, learning the job. Petitioner also took some classes on photo voltaic, which is sun or solar power.

Petitioner worked for S & H for approximately four to five years before he was employed by respondent. His work for S & H was strictly residential. His work for respondent was more commercial than residential. Petitioner was laid off at the end of 2009 due to lack of work.

Petitioner did not seek medical treatment until February 11, 2010 (sic). He testified he was losing mobility and a lot of grinding was going on in his shoulder while working for respondent.

Petitioner had a previous right shoulder surgery by Dr. LaBelle of OAD Orthopedics in 1998 due to football related injury. Petitioner returned to Dr. LaBelle in March, 2006 due to additional shoulder problems. Petitioner was released to return to full duty work on April 17, 2006. Petitioner denied receiving any treatment by Dr. LaBelle between April 17, 2006 until February 1, 2010. Petitioner did not seek treatment for his shoulder pain that started in 2009 as there was not a need for it; he took a couple of days off and Tylenol.

After performing an examination of petitioner on February 1, 2010, Dr. LaBelle referred petitioner to Dr. Bare. Petitioner was offered injections or surgery and placed on modified work. Petitioner sought a second opinion from Dr. Guido Marra on April 13, 2010. At the direction of Dr. Marra, petitioner obtained a CT scan of the right shoulder on April 15, 2010 at Loyola. Petitioner followed up with Dr. Marra on April 20, 2010 and July 13, 2010. Dr. Marra performed arthroscopic surgery on August 16, 2010. As the condition was worse than first thought, Dr. Marra performed another surgery on August 25, 2010 at Gottlieb Hospital, at which time Dr. Marra completely opened up petitioner's shoulder.

Petitioner followed up with Dr. Marra. Physical therapy began on August 31, 2010 at DuPage Medical Group Physical Therapy. On January 25, 2011, petitioner was discharged from physical therapy to a home exercise program; an FCE was recommended.

At respondent's request, petitioner was evaluated by Dr. Theodore Suchy on February 17, 2011.

Dr. Marra wrote a script for physical therapy on January 28, 2011. Petitioner had a FCE on January 9, 2012, which had been delayed for a year as it was not authorized. Petitioner returned to Dr. Marra on February 28, 2012 and was released to return to work with the restrictions set forth in the FCE.

Petitioner met with vocational counselor Michelle Peters Pagella on April 30, 2012. Petitioner did not work for anyone between February 5, 2010 and July 5, 2012. Petitioner looked

for work within his restrictions starting on approximately February 2, 2012. Petitioner was hired at a Volkswagen dealership in Schaumburg as a delivery coordinator earning $9 an hour.

Petitioner trained as a salesman; which he became within six or eight months after starting. As a salesman, petitioner was paid a base salary and received bonuses according to his performance. He identified his paycheck stubs from the dealer for his pay from July 5, 2012 through March 24, 2016 (PX.23). Included in the stubs are from the Volkswagen store in Joliet where petitioner was working at the time of hearing as the internet sales manager. He was being paid $500 a week plus commission and bonuses.

Petitioner left the electrician's union the summer after his claimed injury.

Petitioner testified he no longer can throw; his range of motion in his shoulder is limited and is unable to perform overhead work. Petitioner was told he will eventually require shoulder replacement. His shoulder wakes him up at night.

On cross-examination petitioner admitted it was a football injury in 1998 that necessitated the surgery and his shoulder dislocated approximately twenty before the surgery was completed. Petitioner agreed he saw Dr. LaBelle in August, 2004 with shoulder soreness and was recommended to avoid overhead reaching. He was also seen by Dr. LaBelle in March, 2006.

Petitioner did not recall if he told Dr. LaBelle on February 1, 2010 that he felt better after the 1998 surgery but over the past five years had gradually increasing pain and loss of movement. Petitioner also did not recall telling Dr. Bare on February 5, 2010 that he had pain in his shoulder over the last ten years.

Petitioner confirmed he used drills, hammers and hacksaws while working for S & H in the five years before he worked for respondent.

Petitioner confirmed he received unemployment after he was laid off by respondent in December, 2009.

Petitioner confirmed Dr. LaBelle put hardware in his right shoulder at the time of the 1998 surgery.

Petitioner participated in sports such as basketball, baseball and weight lifting after the 1998 surgery until his shoulder started to hurt and he had limited range of motion.

Richard A. Grant Testimony

Richard Grant testified in behalf of respondent. He was respondent's foreman/owner from May, 2004 until he retired in March, 2014. Respondent did residential, commercial and street lighting. He hired petitioner in early 2009 as an electrician. Petitioner's job with respondent required him to do service jobs. Grant estimated that petitioner worked only one percent of the time on street lighting, which was done with a crane. Grant estimated 99 percent of petitioner's job was to use hand benders to bend conduit. Petitioner was hired by respondent as a foreman.

Application for Adjustment of Claim (PX.1)

Dr. Guido Marra/Loyola Medical Center Records (PX.2)

These records confirm petitioner was first seen by Dr. Marra with a history of undergoing a previous arthroscopic instability surgery in 1998 and noted progressive pain and loss of function in his shoulder. He was diagnosed with end-stage osteoarthritis and was recommended for a shoulder replacement. X-rays confirmed end-stage osteoarthritis. The April 15, 2010 CT scan showed osteoarthritis and exposure of one of the pervious surgery sutural anchor.

On April 20, 2010 Dr. Marra discussed surgery, which was performed on August 16, 2010. Dr. Marra performed extensive arthroscopic debridement for osteoarthritis of petitioner's right shoulder and retained metallic suture anchor.

Dr. Guido Marra June 16, 2010 letter (PX.3)

Dr. Marra authored a report to Lawrence Cassano opining "Clearly heavy activity with a prominent suture anchor would be a clear and competent cause of his arthritis at his age."

Dr. Guido Marra January 7, 2011 Deposition (PX.4)

Dr. Guido Marra testified in behalf of petitioner. He first examined petitioner on April 13, 2010 (P.7). Petitioner advised he previously seen another surgeon who had recommended a total shoulder replacement (P.8). Petitioner had restricted range of motion (P.9). Based upon the X-rays, Dr. Marra diagnosed end stage osteoarthritis and prominent suture anchors from a previous surgery (P.10). A CT scan was ordered (P.10).

Petitioner returned to Dr. Marra on April 20, 2010 after obtaining a CT scan (P.10). Dr. Marra believed the suture anchors were prominent, which meant the piece of metal inside the joint was causing the joint damage (P.11). Dr. Marra recommended arthroscopic surgery to evaluate the joint (P.11). Dr. Marra performed exploratory arthroscopic surgery on August 16, 2010 and confirmed petitioner had end-stage osteoarthritis (P.11). Dr. Marra was not able to repair the shoulder arthroscopically (P.13). Therefore, Dr. Marra performed an open surgery on petitioner's right shoulder on August 25, 2010 at Gottlieb Hospital (P.14). This was a posterior arthrotomy (P.15). Petitioner received physical therapy post surgeries (PP. 17-18).

Dr. Marra testified it was his understanding petitioner performed overhead work as an electrician, which included pulling wires. Based upon this understanding, Dr. Marra believed petitioner's employment as an electrician aggravated or accelerated petitioner's right shoulder condition (PP.20-21).

Dr. Marra believed petitioner is unable to return to work as an electrician due to his condition of ill-being. Dr. Marra believed petitioner's inability to work was the result of his repetitive work-related right shoulder injury and the arthritis resulting from that. (P.23)

On cross-examination, Dr. Marra admitted he did not know the period petitioner had worked, or how long he worked for respondent (PP.25-26).

Attached to the deposition was the August 25, 2010 operative report. On that day, Dr. Marra reported her performed a posterior arthrotomy with impaction of the suture for a retained metallic suture in the glenohumeral joint.

Dr. Guido Marra's January 25, 2011 Record (PX.5)

Petitioner returned to Dr. Marra in follow up to his surgeries. Dr. Marra recommended petitioner undergo a functional capacity evaluation to determine his work restrictions.

Dr. Guido Marra's May 11, 2011 Letter to Lawrence Cassano (PX.6)

Dr. Marra responded to an inquiry that he was unaware of early trauma, but opined the prominent suture anchor and subsequent motion is a competent cause of the findings in petitioner' right shoulder.

DuPage Medical Group Physical Therapy Records (PX.7)

Petitioner received physical therapy from August 31, 2010 through January 24, 2011.

Orthopaedic Associates of DuPage Records (PX.8)

These records include the November 18, 1998 right shoulder operative report by Dr. LaBelle. The operative report indicated petitioner has had recurrent dislocations since his shoulder injury a few years ago from playing football. Dr. Labelle performed a right shoulder capsular shift for multi-directional instability; right shoulder extensive anterior and posterior Bankart repairs of labral tears and right shoulder arthroscopic debridement of chondral defect due to right shoulder instability, labral tears, osteoarthritis and anterior dislocations. (PP.13-15)

The medical history form from August 3, 2004 indicates petitioner had right shoulder pain for three or four weeks and the condition was work related (26-27).

Petitioner was also seen for an ankle injury on May 16, 2001 (PP. 25; 29).

Petitioner was seen by Dr. LaBelle on March 19, 2006 for shoulder pain that started on March 18, 2006 and that it was work related (P.27).

Dr. LaBelle wrote a note on March 20, 2006 stating petitioner was off work due to a shoulder injury; was released to return to work light duty March 27, 2006 with no repetitive lifting about shoulder level. He was released to full duty as of April 17, 2006. (P.22).

On February 1, 2010 petitioner completed an intake form indicating he was being seen on that date for a right shoulder problem that started 10 plus years before and that it was work-related (PP.18-19).

According to the history recorded by Dr. LaBelle on February 1, 2010, petitioner indicated his right shoulder pain had been progressing over the past few years having undergone surgery for a labral tear in 1998. According to the records, petitioner advised he had been doing well and back to throwing for five years afterward. He reported over the past five years gradually lost mobility. Dr. LaBelle reported the X-rays showed significant arthritic changes since the 1998 surgery. He was referred to Dr. Bare for surgical evaluation (PP.10-12).

Petitioner was evaluated by Dr. Aaron Bare on February 5, 2010 at the request of Dr. LaBelle. Dr. Bare reported the X-rays showed at least one anterior anchors was not seated in the bone. Dr. Bare determined petitioner had developed degenerative osteoarthrosis over the past five years. Injections and probable surgery were discussed. (PP.7-9)

Petition for Penalties and Attorneys' Fees (PX.9)

Dr. Guido Marra June 28, 2011 Record (PX.15)

Dr. Marra released petitioner to home exercise program and to return in two years.

January 28, 2011 FCE Script (PX.16)

January 9, 2012 Functional Capacity Evaluation (PX.17)

The assessment indicates petitioner is not physically capable of returning to work as an electrician.

Health Connection of Illinois May 11, 2012 Vocational Assessment (PX.18)

Michelle Peters-Pagella performed a vocations assessment of petitioner on April 30, 2012. She concluded petitioner was a candidate for vocational retraining. She further concluded that if retraining was not considered, petitioner would be relegated to entry level customer service type occupation.

Dr. Guido Marra's February 23, 2012 Return to Work release (PX.19)

Dr. Marra released petitioner to return to work within the functional capacity evaluation.

RAGS Electric Yearly Earnings Report for 2009 (PX.20)

This statement showed petitioner earned a total of $58,676.82 in the 48 weeks he worked for respondent in 2009.

EIT Benefit Funds Health & Welfare Statement (PX.20)

The union claims it paid $19,393.06 for petitioner's claimed work injury.

Subpoenaed Records of IBEW Local 134 (PX.22)

According to the union records, petitioner worked for S & H Electric from July 6, 2004 through October 20, 2008 and for respondent from February 2, 2009 through September 30, 2010.

The records also confirm the foreman rate from June 6, 2016 through June 4, 2017 is $49.10 per hour, which is $3.00 more than journeyman.

Earnings Statements/Paystubs from Schaumburg VW and Hawk VW of Joliet (PX.23)

These are records of petitioner's paychecks received from Schaumburg VW and Hawk VW of Joliet from July 2, 2012 through April 29, 2016; including calculations of the claimed wage-differential.

Medical Bills (RX.24)

Petitioner claims a total of $53,293.39, of which the group insurance paid $39,345.45, petitioner paid $74.40, adjustments made of $9,199.72 leaving an outstanding balance of $4,673.82.

Dr. Theodore Suchy February 17, 2011 Report (RX.1)

Petitioner was examined by Dr. Suchy at the request of respondent on February 17, 2011. Dr. Suchy concluded petitioner had end-stage osteoarthritis of the right shoulder which was the result of injuries from high school football and subsequent stabilization surgery. Dr. Suchy did not believe petitioner's employment as an electrician contributed to petitioner's right shoulder condition in any way or that the surgeries performed by Dr. Marra in 2010 were necessitated in any way by petitioner's employment as an electrician.

Dr. Suchy believed petitioner will likely need a shoulder replacement in the future but it would not be necessitated due to his employment as an electrician.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

B. In support of whether there was an employee-employer relationship on the date of accident, the Arbitrator makes the following conclusions of law:

Petitioner confirmed he was laid off by respondent in December, 2009, which is the last time he performed work for respondent. Therefore, the Arbitrator finds there was no employee-

employer relationship between petitioner and respondent on the claimed date of accident of February 1, 2010.

C. In support of whether an accident occurred which arose out of and in the course of Petitioner's employment with Respondent the Arbitrator makes the following conclusions of law:

There was no evidence to support petitioner sustained injuries to his right shoulder as a result of an accident (repetitive or otherwise) on February 1, 2010, or on any date, that arose out of and in the course of his employment with respondent.

F. In support of whether petitioner's current condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The evidence indicates petitioner's end-stage osteoarthritis to his right shoulder was the result of his previous football injury, dislocations and the 1998 surgery.

This finding is supported by the testimony of petitioner's treating physician, Dr. Marra, that the suture anchors used in the 1998 surgery caused the joint damage. Furthermore, Dr. Marra testified generally that petitioner's condition of ill-being was accelerated and aggravated by petitioner's job as an electrician, without knowing how long or when petitioner actually worked as an electrician for respondent. However, the testimony by Richard Grant that petitioner did service jobs, which required him to use a hand held bender, dispels the suggestion that petitioner did overhead work.

The records of Dr. LaBelle and Dr. Bare confirm petitioner had complaints of pain to the right shoulder for the five years before petitioner's visit in February, 2010, without any mention of his employment as an electrician.

Finally, Dr. Suchy who examined petitioner at respondent's request, believed petitioner's end stage osteoarthritis was caused by the previous football injury and the subsequent stabilization surgery and not aggravated or accelerated by his employment as an electrician.

For these reasons, the Arbitrator finds petitioner failed to prove his employment with respondent caused his right shoulder problem in any way or at any time.

As the Arbitrator has determined petitioner failed to prove that there was an employee-employer relationship on the date of the claimed accident; or that petitioner had an accident that arose out of and in the course of his employment with respondent; or that petitioner's current condition of ill-being is causally related to the claimed accident, all other issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kim Ball,

Petitioner,

vs.

NO: 08 WC 53750

Monterey Coal Company,

18IWCC0170

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission agrees with the Arbitrator's award of permanent partial disability pursuant to §8(d)2 of the Act. After carefully reviewing the record, the Commission finds Petitioner failed to meet his burden of proving entitlement to a wage differential award pursuant to §8(d)1 of the Act. To qualify for a wage differential award pursuant to §8(d)1 Petitioner must prove two things: 1) a partial incapacity which prevents him from pursuing his "usual and customary line of employment," and 2) an impairment of his earnings. An award of a wage differential "...presumes that but for his injuries, the claimant would have been in full performance of his duties." *Dawson v. Workers' Comp. Comm'n*, 382 Ill. App. 3d 581, 586, 888 N.E.2d 135 (Ill. App. Ct. 2008).

Petitioner injured his back and left shoulder in a non-occupational fall in November 2007. Respondent closed the coal mine one month later. Petitioner ultimately underwent back surgery in February 2008 and left shoulder surgery later that year due to his injuries from the non-occupational accident. There is no dispute that Petitioner never attempted to find a new job in the mining industry once his doctors cleared him to return to work following the surgeries. Instead, Petitioner chose to begin working at R.P. Lumber in June 2009.

Although Petitioner contends that he would have continued his mining career absent his respiratory issues, the evidence reveals otherwise. Petitioner testified that at the time of his November 2007 non-occupational accident, he had already decided to leave the mining industry

18IWCC0170

due to his allegedly worsening asthma. However, the medical records do not support this contention. Instead, Dr. Comerford's records reveal Petitioner did not raise any complaints relating to his asthma in the two years preceding Petitioner's last date of exposure in November 2007. The Commission notes that Petitioner visited the doctor during this period to address various other ailments. In fact, prior to the November 2007 fall Petitioner last discussed his asthma with Dr. Comerford in November 2004. This was a routine follow-up visit and there is no indication that either Petitioner or Dr. Comerford were concerned about any worsening respiratory symptoms. Petitioner worked in the mining industry for at least a decade following his asthma diagnosis. The Commission also notes that following the November 2007 non-occupational accident, there is no evidence that Petitioner complained of respiratory issues or concerns of worsening asthma symptoms in the year and a half he was off work recovering from his back and left shoulder surgeries. Petitioner also testified that no doctor recommended he cease working in the mining industry due to his asthma prior to Petitioner's admitted decision to leave the industry prior to November 2007.

The evidence suggests Petitioner decided to leave the mining industry in 2007 for reasons unrelated to his long-diagnosed asthma. Thus, the Commission finds Petitioner voluntarily removed himself from his chosen occupation and is not entitled to a wage differential award.

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 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 $38,269.00. 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: MAR 21 2018

o: 2/20/18
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BALL, KIM
Employee/Petitioner

Case# **08WC053750**

MONTEREY COAL COMPANY
Employer/Respondent

18IWCC0170

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:

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

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
620 E EDWARD ST PO BOX 335
SPRINGFIELD, IL 62705

18IWCC0170

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

Kim Ball
Employee/Petitioner

v.

Monterey Coal Company
Employer/Respondent

Case # 08 WC 53750

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 **Springfield**, on **6/20/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **11/09/07**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner was last exposed to coal dust and fumes arising out of and in the course of employment.

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

In the year preceding the last date of exposure, Petitioner earned **$67,231.13**; the average weekly wage was **$1,292.91**.

On the last date of exposure, Petitioner was **51** years of age, ***married*** with **0** dependent children.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $636.15 per week for 60 weeks, because the injuries sustained caused a 12% 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

9/14/17
Date

SEP 15 2017

STATEMENT OF FACTS

Kim Ball was born on 9/12/56 and is currently 60 years old. He is married with no children under 18. He graduated from Girard high school and obtained an associate's degree in coal mine technology from Wabash Community College. He testified that he worked as a coal miner for 30 ½ years with 28 of those years being underground. He was regularly exposed to coal dust, silica dust, roof bolting glue fumes, diesel fumes and coal fire fumes. He last worked as a coal miner on 11/09/07 for Respondent at Mine 1. He was a plant operator repairman at that time and was exposed to coal dust on that day. That last day was a Friday and on Sunday he fell in his garage and hurt his back. He saw a doctor the following day, 11/12/07. He never went back to work for Respondent and the mine closed at the end of December of 2007. At that time, he also had asthma problems. He did have back surgery. With the breathing issues, he had decided that it was safer to stay out of the mine. He had made his mind up not to go back because of lung issues, breathing problems. He did not look for any other coal mining work. He was off work for a year with his back. He did look for work and found a job with R.P. Lumber in June of 2009 and continues to work for them to this day. He builds loads and delivers loads of lumber. They use a forklift. Presently he makes $13.75 an hour and works 40 hours a week. When he started out, he was making $10.00 an hour. That is the only job he has had since he worked as a coal miner.

His whole mining career was with Respondent beginning in September of 1978. Initially, he worked as a laborer which involved shoveling on the beltline or he could be rock dusting. After a couple of years, he became a mover, which involved moving the conveyor belts. He then became a roof bolter which involves putting pins in the roof to support it. He then became a pumper examiner which involved keeping the water pumped out. Petitioner then became an examiner which involved looking at certain areas of the mine for accumulation of gas or dust. He next bid on top to become the plant operator repairman. He was having trouble breathing with asthma problems. In that job, he ran the plant, including loading coal trains. You repaired anything that broke down in the plant. There was a lot of cutting and welding. They also used glues to keep the cement tiles in place. There was less exposure to dust but more exposure to welding fumes and glues. There was also exposure to diesel fumes. He first noticed breathing problems when he was roof bolting which was probably in the early 1990's. His chest would start tightening up. At that point, he was diagnosed with asthma, sometime in the 1990's. He had not had any asthmatic problems before becoming a coal miner. From the first notice of breathing problems until he left the mine, they became worse. Since leaving the mine, the problems have worsened. He can walk about two blocks on level ground before becoming short of breath. He can probably climb three to four flights of stairs. He takes Advair twice a day and carries an inhaler with him at all times, ProAir. He had to use it the night before the hearing after mowing the yard. He probably uses it two or three times a week, depending upon activity. Breathing has affected his daily activities by slowing everything down. It feels like something is on his chest and if he takes a couple of puffs, it usually goes away. He continues to do woodworking. He does not do much hunting anymore. His wife cannot wear perfume anymore. She does not burn candles anymore. The laundry detergent has to be unscented. He had a blood clot last year and is currently on a blood thinner. He has acid reflux and takes a pill for that. But for breathing difficulties he would have continued his coal mining career. As of 1/01/16, under the Bituminous Wage Agreement, he would be able to earn $30.41. Petitioner indicated that he hurt his back in November and the mine closed in December. He had the back surgery in February of the following year. Petitioner continues to be an Assistant Chief of the Virden Fire Department, which he began in 1986. His job is to man the water trucks to supply the water for the fire. Petitioner joined the EMT rescue squad in 1991 and is still on that. Petitioner indicated that there was not a medical report or doctor's recommendation that he not return to work in the coal industry.

In the medical records from Central Illinois Allergy and Respiratory, there is a chest x-ray interpretation by Dr. Johnson of films taken 7/23/14 which indicates the heart and pulmonary vasculature are within normal limits and there is no evidence of acute pulmonary infiltrates (PX5). There is no mention of any occupational disease or coal workers' pneumoconiosis. The pulmonary function study done on that date included a negative Methacholine challenge. Subsequent pulmonary function studies of August of 2014, November of 2014 and

March of 2015 reveal normal values. Dr. Paul's physical examination of the chest on 11/11/14 revealed no abnormalities (PX5).

The medical records from Petitioner's treating physician, Dr. Comerford, go back to late 1999. A note from 11/10/99 indicates that Petitioner's past medical history was essentially negative except for some difficulty with asthma. Current medications included Azmacort and a Ventolin inhaler. The physical examination of the chest was normal. The office note from 11/19/09 indicates under assessment that Petitioner was a healthy male. As of 6/28/11, the physical examination of the chest was normal. Petitioner did not complain of shortness of breath, cough or shortness of breath during exertion (PX6). The medical records contain a medical examination report for a commercial driver fitness determination form. With a date of 11/15/13, the doctor indicates that Petitioner is a healthy 57 year old male. Dr. Comerford indicates that Petitioner does not have abnormal breath sounds including wheezes or rales or impaired respiratory function. An office note from 11/15/13 indicates that the Petitioner reported no shortness of breath, no cough, and no shortness of breath during exertion. The pulmonary evaluation portion of the physical exam was normal. As of 7/18/14, Petitioner was complaining of shortness of breath, wheezing, coughing, and shortness of breath during exertion. The pulmonary physical examination was normal. An office note dated 3/18/15 revealed that Petitioner was complaining of cough but no shortness of breath, no wheezing and no shortness of breath during exertion. The pulmonary evaluation revealed diffusely diminished air entry. The office note from 10/12/15 indicates that Petitioner said he had no shortness of breath, no wheezing, no cough and no shortness of breath during exertion. The pulmonary evaluation was normal. The Express Care note from 4/17/16 indicates that Petitioner had no shortness of breath. The physical examination with regard to the lungs was normal (PX7).

An office note from 12/16/16 notes that Petitioner had no shortness of breath, no cough and no shortness of breath during exertion. The physical examination of the lungs was normal. As of 11/16/16, Petitioner had no shortness of breath, no cough, no shortness of breath during exertion. The pulmonary evaluation was normal. An Express Care note from 8/31/16 indicates that Petitioner had no shortness of breath. The respiratory physical examination was normal (RX3).

Dr. Henry Smith reviewed chest x-ray films taken on 2/19/08 and felt they were positive for pneumoconiosis in a 1/0 profusion. He noted that this was seen in the mid to lower zones of both lungs (PX4). Dr. Ralph Shipley reviewed chest x-ray films taken on 10/09/14 and found them negative, with no findings consistent with coal workers' pneumoconiosis (RX2). Petitioner had a CT scan of his abdomen and pelvis performed on 11/23/16. The radiologist noted with regard to the abdomen that the lung bases are clear (RX3).

Dr. Paul evaluated Petitioner on 1/28/09. As of the date of his initial deposition 6/09/14, that was the only time he had ever seen Petitioner (PX1, p. 39). The history provided to Dr. Paul was the Petitioner had worked 30 years as a coal miner and had a 10 year history of asthma. There was a history of wheezing and coughing and shortness of breath, which are symptoms of asthma. The airways are very reactive and with weather changes or irritants or infections or emotional stresses, symptoms can be triggered (PX1, p. 12). Petitioner was taking Advair which works on inflammation and opens up the windpipes. Albuterol also opens up the windpipes and is used as a rescue inhaler when there is an asthma attack. The Advair works as a prevention for those attacks. Despite taking the medication, he still had wheezing, coughing and shortness of breath (PX1, p. 13). Petitioner was never a cigarette smoker. Petitioner had low back surgery in 2008 and rotator cuff surgery in 2008. On the physical examination, no abnormalities were found on the date examined (PX1, p. 14). The pulmonary function test was normal with a positive Methacholine stimulation test. With Methacholine he had a reaction to the first breath (PX1, p. 15). There was a 25% fall. He had this reaction despite being on the medication which makes it even more significant. Dr. Paul diagnosed coal workers' pneumoconiosis (PX1, p. 16). The doctor also diagnosed asthma which he thought was caused by the coal dust environment to include roof bolting glue, diesel fumes, and other adhesives. Petitioner could not have further exposure to the coal mine environment without endangering his health, based upon the diagnosis of CWP and the diagnosis of asthma (PX1, p. 17). Dr. Paul

indicated Petitioner had clinically significant pulmonary impairment based on symptoms and complaints. This is from the coal mine environment. Petitioner had physiologically significant pulmonary impairment as noted on the pulmonary function testing. That is from coal dust (PX1, p. 18). Dr. Paul felt that Petitioner was totally disabled from working in a coal mine. With regard to work activity, some days he would be able to do everything and some days he would not be able to anything depending on the asthma activity. You would not know in advance when symptoms were going to begin. You would not know how long they were going to last even (PX1, p. 19). It would be important for Petitioner to stay away from anything that could trigger asthma attacks. That could include fumes from cars or diesel. It might involve perfume. You might need to stay away from work where there were strong odors or fumes of cooking of food (PX1, p. 21).

Dr. Paul indicated that with coal workers' pneumoconiosis there is some impairment in the function of the lung at the site of the scarring whether it can be measured or not (PX1, p. 23). Further exposure to coal dust in a miner with coal workers' pneumoconiosis may increase the progression of the disease. There are exposures besides dust in a coal mine environment which can injure lungs (PX1, p. 28). These include silica, diesel fumes, fumes from petroleum products, smoke and fumes from coal fires, smoke and fumes from cable fires, fumes from roof bolting glues, and welding fumes. COPD is an umbrella term for a number of obstructive diseases including asthma (PX1, p. 29). Exposures in the coal mine environment can result in occupational asthma. The exposures can aggravate asthma. If a person has COPD, the best medical practice is to avoid further exposure to agents that can cause or aggravate it (PX1, p. 33).

Dr. Paul's cardiac evaluation was normal. His chest evaluation was normal. The diffusing capacity and the total lung capacity were within normal limits (PX1, p. 40). There was no evidence of a restrictive lung problem. There was no evidence of emphysema. Petitioner's symptoms were worse when he had an upper respiratory infection (PX1, p. 41). Dr. Paul did not know if Petitioner took his Advair on the day he was seen. The clinically significant pulmonary impairment was from his symptoms related to asthma (PX1, p. 42). The physiologically significant pulmonary impairment was from asthma.

Since Dr. Paul's first deposition, he saw Petitioner for treatment for his asthma (PX2, p. 5). This lasted from 7/23/14 to 8/05/15. On the initial date, the doctor took a brief history and treated the asthma. The doctor noted asthma and allergic rhinitis (RX2, p. 6). Petitioner was taking allergy shots. He had ProAir which is a rescue inhaler. He also had Advair which is an anti-inflammatory and preventive. The doctor indicated that Petitioner still had asthma and coal workers' pneumoconiosis (PX2, p. 7). Dr. Paul indicated that Petitioner was about the same from the evaluation of 2009 through the time he was treating in 2014-2015 (PX2, p. 8). Dr. Paul did not think there was anything with regard to Petitioner's lumber yard job that would aggravate his asthma. Allergy testing revealed allergies to dust mites and cats (PX2, p. 9). If Petitioner has contact and develops allergic rhinitis, he could trigger asthma (PX2, p. 11). The symptoms of cough, shortness of breath and wheezing could come into play. Based on Petitioner's history of asthma for 10 years, he would have had it when he worked as a coal miner (PX2, p. 12).

June Blaine is a rehabilitation counselor (PX3, p. 5). She performed an evaluation of Petitioner at the request of his attorneys (PX3, p. 5-6). She met with Petitioner on one occasion, 9/27/16 (PX3, p. 7). After high school, Petitioner completed an associate's degree in coal mine technology. When he went to work for Respondent, he obtained his mine papers and then his mine examiner papers (PX3, p. 8). June Blaine did not perform vocational testing because Petitioner presented with an associate's degree (PX3, p. 9). Petitioner went to work at R.P. Lumber in Springfield and then Chatham. He puts together loads for residential and commercial lumber and drives a 1 or 2 ton truck to make deliveries. He had been working there since 2009 and is currently making $13.75 an hour. He works 40 hours a week (PX3, p. 10). She did not feel that Petitioner could earn what he was earning in the mine. She felt that what he was currently doing was appropriate considering the job market (PX3, 12). Petitioner indicated to her that he was making $23.00 an hour for Respondent but she did not have any documentation of that (PX3, p. 16). With regard to the lumber yard job, she indicated she assumed that lifting

something that might be heavy would be involved. Specifically, she thought he would have to lift at least 50 pounds so that the job would be somewhere between medium and heavy. She thought that would be consistent with his coal mine jobs (PX3, p.15). She did not perform a labor market survey and was not evaluating Petitioner to try to find him a different job or prepare a resume (PX3, p. 17).

Dr. Peter Tuteur evaluated Petitioner on 10/09/14. Dr. Tuteur took a history and performed a physical examination (RX1, p. 6). He reviewed pulmonary function study results and chest x-ray films. With regard to the pulmonary function study, the FVC and FEV1 values were within the normal range (RX1, p. 7). The total lung capacity was within the normal range (RX1, p. 7-8). There was no evidence of a restrictive problem. The diffusing capacity was within the normal range. The arterial blood gas results at rest and with exercise were within the normal range. The oxygen saturation was within the normal range before, during and after exercise. The FEV1 was stable measured before and after the exercise. The FEV1 is reduced with exercise in a person with bronchial reactivity which is induced by exercise. The chest x-ray films were with normal limits (RX1, p. 8). There was no evidence of coal workers' pneumoconiosis. On the physical examination of the chest, there were no abnormal findings. Petitioner was in the obese range. With extra weight, a person begins to experience breathlessness at an early level of exercise because of the overweight status (RX1, p. 9). Dr. Tuteur indicated he would recommend that Petitioner not be exposed to any conditions or materials that exacerbate his respiratory symptoms. Based upon his evaluation, Dr. Tuteur indicated that Petitioner did not have medical coal workers' pneumoconiosis. He did not diagnose either emphysema or chronic bronchitis (RX1, p. 11). Dr. Tuteur indicated that Petitioner has bronchial reactivity from working as a coal miner and it would be in his best interest not to be in the environment of a coal mine again (RX1, Exh. 2)

CONCLUSIONS OF LAW

Dr. Paul diagnosed coal workers' pneumoconiosis from a chest x-ray film when he saw Petitioner on 1/28/2009. Dr. Smith reviewed a chest x-ray film dated 2/19/08 and found it positive for coal workers' pneumoconiosis. To the contrary, Dr. Shipley reviewed more recent films dated 10/09/14 and found them to show no evidence of coal workers' pneumoconiosis. Dr. Tuteur testified he saw no evidence of coal workers' pneumoconiosis on the chest x-ray films of the same date and indicated that Petitioner did not have coal workers' pneumoconiosis based upon his entire evaluation. The Arbitrator also notes the 11/23/16 CT scan. While Dr. Smith noted that the coal workers' pneumoconiosis was in the lower lung zones bilaterally, the CT radiologist indicated that the lung bases were clear (RX3). Further, Dr. Johnson did not diagnose coal workers' pneumoconiosis when he reviewed films taken on 7/23/14, in conjunction with a Dr. Paul office visit. The Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he has developed coal workers' pneumoconiosis.

With regard to asthma, the history to Dr. Paul was that Petitioner had asthma for 10 years. The medical records reflect such a diagnosis as of 11/10/99 (PX6). Dr. Paul diagnosed asthma, which he related to exposure to the coal mine environment. Dr. Tuteur's report noted that Petitioner had bronchial reactivity most likely associated with exposure to materials associated with roof bolting glue bolts as a coal miner. Dr. Comerford's records reflect ongoing medication for asthma. Based on this medical evidence, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he has asthma or bronchial reactivity which is related to his exposures with Respondent.

With regard to permanency, Dr. Tuteur's pulmonary function studies were normal. His physical examination of the chest was normal. The exercise testing was normal. Dr. Paul's pulmonary function test was initially normal. The Methacholine challenge test was positive, reflecting the asthma. His physical examination of the chest was normal. Dr. Paul felt Petitioner had clinically significant and physiologically significant pulmonary impairment because of his asthma. Without any symptoms of asthma, Dr. Paul said Petitioner could do everything. Petitioner did not have exercised-induced bronchial reactivity. Dr. Paul indicated that further coal mine exposure could endanger Petitioner's health. Dr. Tuteur indicated it would be in Petitioner's best interest not to

be in a coal mine environment again. Petitioner indicated that no doctor recommended that he leave coal mine employment. He worked for at least 8 years (1999-2007) as a coal miner with a diagnosis of asthma. He testified that at the time of his back injury, he had decided not to go back to work for Respondent because of the breathing issues. He did not look for other coal mining work. Petitioner's back injury occurred on 11/11/07 and Respondent closed the mine in December of 2007. Petitioner mentioned problems with perfume, candles and scented laundry soap. He continues to be an Assistant Chief of the Virden Fire Department and a member of the EMT rescue squad. He continues to work 40 hours a week at R.P. Lumber, where he has been employed for 7 ½ years. Some lifting is involved. Petitioner's last two pulmonary function tests in November of 2014 and March of 2015were normal. The most recent office notes from Dr. Comerford in December and November of 2016 say that Petitioner had no shortness of breath, no cough, and no shortness of breath with exertion. There is no mention in these notes of any problems Petitioner was having with his asthma or bronchial reactivity.

Although Petitioner certainly has asthma or bronchial reactivity, the medical records do not suggest that Petitioner has symptomatology on a regular basis. Based on the medical evidence, the Arbitrator finds that Petitioner is entitled to 12% man as a whole.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Adono

Petitioner,

vs.

NO: 15WC 32404

Flanders,

18IWCC0171

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, prospective medical care, 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 12, 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: MAR 2 2 2018
SJM/sj
o-3/1/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

ADON, MARIA
Employee/Petitioner

Case# **15WC032404**

FLANDERS
Employer/Respondent

18IWCC0171

On 7/12/2017, 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 1.12% 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:

5755 COSTA IVONE LLC
JULIO COSTA
6847 W CERMAK RD
CHICAGO, IL 60607

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

18IWCC0171

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(A)

Maria Adono
Employee/Petitioner

v.

Flanders
Employer/Respondent

Case # **15** WC **32404**

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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **New Lennox**, on **6/9/17**. 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 _____

FINDINGS

On the date of accident, **5/13/15**, 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 **$16,776.76**; the average weekly wage was **$322.63**.

On the date of accident, Petitioner was **53** 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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$6,762.46** for other benefits, for a total credit of $6762.46. ARB EX 1.

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

ORDER

Respondent shall pay Petitioner TTD benefits for the period of 62-6/7 weeks at a rate of $286.00, from September 15, 2015, through February 23, 2016, and September 2, 2016, through June 9,2017.

Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in the care and treatment of her bilateral shoulder and cervical conditions pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Respondent shall authorize and pay for the prospective medical treatment prescribed by Dr. Poepping regarding both shoulders and all attendant care pursuant to Sections 8 and 8.2 of the Act.

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

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

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

Carolyn M. Wheesy

Signature of Arbitrator

7/11/17

Date

JUL 12 2017

FINDINGS OF FACT

At trial, the 53 year old Petitioner testified via interpreter. Petitioner testified that she began working for Respondent in April 2012. Petitioner testified that between May 2014 and May 2015, she worked on the line as a filter inspector. RX 6 contains two job videos. It was agreed by the parties at trial that the second video at RX 6 depicts Petitioner's job duties in May 2015. Petitioner testified that she worked the depicted duties 10 hours per day for a little over one year

Specifically, the job video depicts the worker standing at a counter surface, reaching for and taking a common light weight air conditioning filter, standing the filter vertically, placing a paper label on the top portion of the filter and then stacking the filters. The filters depicted in the video were 20x20 and Petitioner testified the filters come in different sizes. Regardless of the filter size, the filters are always stacked 24 filters high. Petitioner testified that when she stacks the filters 24 high her arms are "high" and the stack is over her head. Petitioner testified that the filters are then boxed by another worker and that she makes enough filters to fill 23 to 24 boxes per hour, 9 hours per day excluding lunch and breaks.

Petitioner testified that the smallest filter size is 12x12 and her arms are at chest height when working with that size filter. The largest filter is 25x30 and Petitioner testified that her arms are "very high" and she must reach above shoulder level standing on her toes to place the paper on that size filter and stack the filters. Petitioner testified that she most commonly worked with multiple size filters including 16x25, 20x25, 25x25 and 20x30. She further testified that these sizes are larger and higher that the filters depicted in the video. She testified that as a result of the filter size she commonly works with, she is always working above shoulder level and over head to place the paper labels and stack the filters. Petitioner testified that once the filters are stacked, she places a 2-3 pound wood board on the stack to weigh down the filters. Petitioner estimated that a stack of 24 filters weighs over 10 pounds. Regardless of size, the filters are 1 inch thick. A stack of 24 filters is 24 inches high.

Respondent called Dustin Stream to testify in his current capacity as the production supervisor. He testified that in 2015, he worked with Petitioner and supervised her line. He agreed that video 2 at RX 6 is an accurate representation of Petitioner's job duties and that it depicted Petitioner's exact job duties. He further agreed that lifting the paper label to put it on the filter requires Petitioner to extend her arms above shoulder level because Petitioner is short. Specifically, he testified that Petitioner extended her arms above shoulder level when working with any filter of 20 inches or larger 9 hours per day. He agreed that Petitioner handled approximately 2400 filters per day which would require her to raise her arms above shoulder level. He estimated a stack of 24 filters weighed 3 pounds as the filters themselves weighed only ounces.

Petitioner testified that she began work at 5:30 am and took her 10 minute break at 8:10 am, 30 minute lunch at 11 am and the last 10 minute break at 2 pm. Her work day ended at 4 pm. Petitioner testified that on May 13, 2015, she had been working several days with 20x25 filters. She testified that on May 13, 2015, she worked 5 hours noticing pain in neck and both shoulders. Petitioner testified that the pain was intense and that she told her supervisor about the pain before leaving early due to pain. Petitioner testified that she did not have any prior neck or shoulder injuries.

On May 13, 2015, Petitioner reported to Dr. Powell at Riverside Health accompanied by a friend to interpret. Dr. Powell was her husband's primary care doctor. Petitioner testified that she told Dr. Powell that the pain started 6-7 months prior and that she did repetitive motion at work. His records reflect a history of bilateral shoulder pain for 6-7 months with right shoulder pain radiating down the right arm to the right hand with some numbness. He noted, "PT does a lot of lifting at work." PX 1. Petitioner advised that her right hand numbness

and tingling was worsening and that she uses her "right hand and arm a lot at work with repetitive motions but has numbness to the left occasionally too." Under a diagnosis of right shoulder pain, right arm paresthesia and right hand and arm weakness, Dr. Powell ordered an MRI of the right shoulder.

The MRI was performed on 6/12/15 and showed tendinopathy and high-grade partial thickness tear of the supraspinatus tendon and subacromial space bursitis. PX 2 PX 3.

Petitioner was sent to the company clinic at Oak Orthopedics. On July 8, 2015, Dr. Antkowiak noted bilateral shoulder pain right worse than left with an onset date of February 1, 2014. He noted it was a work injury and that Petitioner worked for Respondent doing inspection. In the notes he specified that Petitioner feeds paper into a machine and gradually stared having pain in her shoulder right worse than left. He noted she "has most difficulty with lifting and repetitive cross body movements. She had an MRI done at RMC." Physical exam revealed a positive Hawkins and Neer's testing on the right and left. He noted the same MRI findings on the right shoulder and initiated physical therapy and a home exercise program. A possible steroid injection was also noted along with surgery on the right shoulder should conservative care fail. Petitioner was returned to work with restrictions of no repetitive overhead motion and no lifting over 10 pounds.

The initial physical therapy record from 7/17/15 and 9/1/15 also reflect the onset of symptoms in February 2015 as a result of repetitive work, and that Petitioner's work activities consist of constant repetitive movements and frequent overhead movements causing discomfort in both shoulders. Petitioner reported that her current work conditions continued to aggravate her symptoms and that she is unable to modify her work environment to complete pain free work activities. PX 3.

On 8/5/15, Petitioner reported that physical therapy did not help and that she had continued pain in both shoulders right worse than left but that the left pain was increasing. Petitioner elected to proceed with the cortisone injection. As of 9/4/15, Petitioner reported little improvement with the injection and that her left shoulder pain was now equal with the right shoulder. Petitioner elected to proceed with surgery on the right shoulder pending approval.

Petitioner testified that the right shoulder surgery was not approved so she sought another opinion on 9/18/15 from Dr. Vargas, her second choice of physician. Dr. Vargas noted Petitioner's onset of bilateral shoulder pain and neck pain and shooting radiation on the right side. Dr. Vargas ordered a cervical MRI which revealed disc pathology with corresponds with the patients ongoing clinical symptoms and physical findings. PX 5. Dr. Vargas recommended cervical injections which he performed on 10/23/15 and 11/13/15. AS of the visit on 11/25/15, Petitioner reported significant improvement in her cervical symptoms following the injections. However, she continued to exhibit mild C5-6 radiculopathy and posterior cervical axial neck pain and was scheduled for a third and final injection. The third cervical injection occurred on 12/11/15. However, Petitioner's symptoms returned after increasing her ADL's following the first two injections. Petitioner was referred for a neurosurgical consultation for her cervical complaints. Petitioner was taken off work as of 11/24/15.

Petitioner was sent by Dr. Vargas to orthopedic surgeon Dr. Poepping at Windy City Medical Specialists on 10/5/15 for her shoulder complaints. PX 5, PX 6. Petitioner reported her bilateral shoulder pain and that she works above shoulder level with repetitive type motions which resulted in right shoulder pain beginning in February 2014. He also noted, "she had an injury to the left shoulder at work when she slipped and fell and grabbed with her left arm which caused pain in this shoulder." He noted that physical therapy had failed and following MRI review recommended surgery on the right shoulder including subacromial decompression, distal clavicle excision and evaluation of rotator cuff repair. She remained under work restrictions pending surgical

approval. The restrictions were no lifting over 5 pounds, no lifting above chest height and no operation of machinery or tools. PX 6.

On 11/16/15, 2/22/16, and 5/2/16, Dr. Poepping again recommended right shoulder surgery. As of 6/1/16, the surgical recommendation was switched to the left shoulder as it was now the primarily symptomatic shoulder. Left shoulder surgery was again recommended on 7/22/16. At the visit on 9/2/16, Petitioner reported a worsening of symptoms bilaterally in her shoulders in that she was forced at work to do things against her restrictions. As a result, she was taken off work on 9/2/16. As of 10/28/16, the right shoulder was worse than the left but Petitioner still wanted to start with the left shoulder surgery first followed by the right shoulder surgery. Left shoulder surgery was again recommended on 12/16/16 and 3/10/17. Petitioner was continued off work pending surgery. PX 6.

In January 2016, Petitioner was seen by Dr. Erickson for a cervical surgical consultation. Dr. Erickson's records reflect a report that Petitioner "fell on to an assembly line. She did not fall completely to the floor but was caught before falling completely. The sudden awkward movement was associated with a popping sensation and an increase in her neck pain." PX 7. He reviewed the October 2015 cervical MRI showing small disc herniations at C4-5 and C5-6. An EMG/NCV test was ordered and on 3/23/16, Dr. Erickson noted that the findings were non specific and alluded to multiple root problems on the right side in the cervical space. PX 7. Petitioner had no further visits with Dr. Erickson. He also ordered SSEP testing which was never performed. PX 7.

Currently, Petitioner testified that both shoulders hurt the same amount but she wants the left shoulder surgery to be done first. A utilization review for the right shoulder surgery request was performed on 9/16/15 and the surgery was found to be medically necessary. The approved surgery was arthroscopy with rotator cuff repair and subacromial decompression. PX 10.

Dr. Poepping testified via evidence deposition on 10/25/16. He reviewed the job videos at RX 6. Dr. Poepping opined that Petitioner's bilateral shoulder condition was causally related to her job duties based on "an MRI that correlates with her mechanism of injury being overhead activity at work." PX 9. He opined that both shoulders need surgery and that it depends on which shoulder is more symptomatic at the time of surgery. On cross-exam, he again testified that it was Petitioner's overhead work that caused her condition regardless of the weight of the filters. PX 10.

The deposition of Dr. Verma, Respondent's Section 12 physician was taken on 2/22/17. RX 4. He first examined Petitioner on 12/2/15. He testified that Petitioner did not describe overhead activity to him and demonstrated table top level work between the waist and shoulder. He noted Petitioner was 5 feet tall. Following his review of the MRI exams of the right and left shoulders he diagnosed left shoulder impingement, moderate, right shoulder impingement and secondary partial rotator cuff tear. RX 4. The second exam took place on 12/23/15 where he reviewed a written job description which noted lifting up to 15 pounds, bending, stopping, squatting, repetitive motions with hands and arms and standing at work station for long periods of time with continuous walking. He requested further information regarding the level of Petitioner's arms while working and deferred an opinion on causal connection. However he did agree that right shoulder surgery was necessary. RX 4, p. 17.

Dr. Verma reviewed the job videos at RX 6. In February 2016, he authored an addendum report based on the video review and opined that the filters appeared light and that the work was done below shoulder level. RX 4, p. 19. He opined that he did not see anything on the video that would be associated with an increased risk of

shoulder impingement or rotator cuff tear. He opined that the bilateral shoulder conditions were attributable to the natural aging process.

Dr. Bernstein performed a Section 12 exam for Petitioner's cervical complaints. He opined that her cervical condition was unrelated to her work duties and that she suffered "no injury whatsoever." RX 5. He determined Petitioner had a "completely benign cervical MRI with mild degenerative changes" and did not consider the findings to be symptomatic. RX 5.

When asked about the light duty work she was asked to perform throughout the pendency of her claim, Petitioner recalled a task she was given during the week of August 25, 2015 when she was asked to scrap glue off a drain with a spatula. Petitioner testified this caused an aggravation of her symptoms and she did not come back to work pursuant to Dr. Poepping's orders. PX6. Petitioner testified no one contacted her regarding light duty work after September 2, 2016. Mr. Stream testified that Petitioner worked light duty in the box coding department putting labels and stickers on boxes for her first round of light duty. On her second round in 2016, he testified that Petitioner was assigned light janitorial work sweeping and cleaning half the day and the other half of the day she sat the line to help label as the box department was gone. He agreed that Petitioner cleaned glue from a sink and that she did have to apply pressure with a rag and spatula to remove the more stubborn glue. He further testified that he never told Petitioner that light duty was not available and that he followed the light duty restrictions. He testified that Petitioner quit work as of 9/16/16 despite the offer of continued restricted duty.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

(C) Did an accident occur that arose out of and in the course of Petitioner' employment with Respondent? (F) Is Petitioner's current condition of ill-being causally related to the injury?

Based on a preponderance of the credible evidence at trial, the Arbitrator finds that Petitioner sustained a work-related repetitive trauma type injury that arose out of and in the course of her employment for Respondent and manifested on 5/13/15. In so finding, the Arbitrator notes that Petitioner had no problems with her shoulders or cervical area prior to working as a filter inspector. Petitioner testified that at first her symptoms were not severe but they progressively got worse. Petitioner testified she worked with pain, and it wasn't until May of 2015 that her pain became severe, prompting her to seek medical attention for the first time. Petitioner's testimony is buttressed by the initial treating medical records of Dr. Powell which document bilateral shoulder pain radiating down her right arm to her right hand with some numbness, which she had been experiencing for approximately 7 months.

The Arbitrator further notes Petitioner's testimony regarding the detailed nature of her job duties was credible, despite any confusion in conveying those details at trial. Petitioner testified that she stood on a line for 9 hours per day reaching for air filters of varying sizes, standing them vertically, applied a paper label to one side of the filter and then stacked the filters 24 high. Petitioner testified that she prepared approximately 2,000 filters per shift using a rough estimate of 24 boxes per hour each containing 12 filters. Petitioner's testimony was confirmed by the job video 2 of RX 6. Petitioner's testimony was confirmed by Mr. Strean. The Arbitrator further notes that Petitioner is 5 feet tall and as a result, Petitioner's arms were above shoulder level and overhead while she stacked the admittedly light weight filters. The repetitive, overhead nature of Petitioner's job duties are documented numerous times in her treating medical records. Based on the job duty description provided by Petitioner, the job video depicting Petitioner's duties, and the agreement of Mr. Stream with

Petitioner's testimony and the video, the Arbitrator finds that Petitioner's job duties were clearly repetitive and required repetitive over head reaching during the entire 9 hour shift. Accordingly, the Arbitrator finds that Petitioner's job duties resulted in her repetitive trauma type injury to her bilateral shoulders manifesting on 5/13/15 arising out of and in the course of her employment.

The Arbitrator further finds that Petitioner's current condition of ill-being in her bilateral shoulders as well as her cervical complaints are causally related to her job duties and manifested injury of 5/13/15. In so finding, the Arbitrator finds the testimony of Petitioner's treating physician Dr. Poeppng more credible than the testimony of Dr. Verma. The Arbitrator notes that both physicians agreed on the diagnosis and necessary treatment for Petitioner's right shoulder complaints and differed only on causation based on a review of the job video 2 at RX 6. Based on the totality of the evidence presented at trial, the Arbitrator finds the opinion of Dr. Poepping more persuasive than that of Dr. Verma.

J) Were the 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?

Based on the Arbitrator's findings on the issues of accident and causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in connection with the care and treatment of her causally related injuries to both shoulders and her neck pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid. ARB EX 1. Respondent's dispute on medical expenses was based on liability. The Arbitrator further notes the UR certification of the right shoulder surgery in finding Respondent liable for the medical expenses incurred as well as the prospective shoulder surgery recommended by Dr. Poepping. The Arbitrator further finds that Respondent shall authorize and pay for the recommended right and left shoulder surgeries as well as the attendant care pursuant to Sections 8 and 8.2 of the Act.

(L) Is Petitioner entitled to TTD benefits from September 18, 2015, through February 23, 2016, and September 2, 2016, through June 9, 2017?

The Arbitrator finds that Petitioner is entitled to TTD from September 18, 2015, through February 23, 2016, and from September 2, 2016, through June 9, 2017. Petitioner continued to treat for her bilateral shoulder complaints and continued to attempt light duty while under a surgical recommendation for both shoulders. Although the Arbitrator notes Mr. Strean's testimony that work was provided within Petitioner's restrictions at all time, the Arbitrator places greater weight on the testimony of Petitioner that she attempted to work the duty offered but was unable to do so based on her continued condition. Further, the Arbitrator notes that Petitioner's testimony is supported by the off work authorization by Dr. Poepping as of 9/2/16. Petitioner is entitled to TTD benefits for a period of 62-6/7 weeks. Respondent shall receive credit for amounts paid.

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

Elizabeth Gonzalez-Rojas,

Petitioner,

vs. NO: 16WC018630

Multi-Temps Staffing, Inc.,

Respondent.

18IWCC0172

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 30, 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.

MAR 22 2018

DATED:
SJM/sj
o-3/1/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

GONZALEZ-ROJAS, ELIZABETH
Employee/Petitioner

Case# **16WC018630**

MULTI-TEMPS STAFFING INC
Employer/Respondent

18IWCC0172

On 5/30/2017, 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 1.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2512 THE ROMAKER LAW FIRM
JASON BRISKI
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

5001 CAIDO & FINTZEN
PETER A HAVIGHORST
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

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

Case # 16 WC 018630

Elizabeth Gonzalez-Rojas
Employee/Petitioner

v.

Multi-Temps Staffing, 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 **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **3/29/2017**. 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 and number of dependents at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **3/17/2016**, 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, in part,* causally related to the accident.

Petitioner's average weekly wage was **$330.00**.

On the date of accident, Petitioner was **48** years of age, *single* with **1** dependent children.

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

Respondent shall be given a credit of **$5,566.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$5,566.00**, for benefits paid for undisputed lost time prior to 9/8/2016.

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 $253.00 per week for 24-5/7 weeks, commencing 9/9/2016 through 3/1/2017**, as provided in **Section 8(b) of the Act.**

Respondent shall pay **reasonable and necessary medical services of $32,792.30**, as provided in **Sections 8(a) and 8.2 of the Act** and as set forth below.

Respondent authorize and pay for the **prospective medical care**, as offered by Dr. O'Keefe regarding Petitioner's right shoulder, to wit: Right shoulder scope with probable open repair of rotator cuff tear, along with all related services and treatment, in accordance with **Sections 8(a) and 8.2 of the Act.**

Respondent shall pay to Petitioner attorney's fees of **$3,904.49**, as provided in Section 16 of the Act; and penalties of**$19,522.47**, as provided in Section 19(k) of the Act; and **$5,190.00**, as provided in Section 19(l) of the Act.

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

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

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

Signature of Arbitrator

May 30, 2017
Date

MAY 30 2017

FINDINGS OF FACT

Petitioner testified via a Spanish/English interpreter.

Petitioner was employed by Respondent as a laborer, doing packing. Respondent is a temporary labor/staffing company. She was paid $8.25 per hour and was scheduled to work 40 hours a week. Petitioner testified that she had no prior low back injuries or back pain. She had no prior right shoulder or arm pain or injuries. She also denied prior workers' compensation claims or prior work injuries. Her date of birth was 11/10/1967. She was not married and 1 child under 18 on the claimed date of accident.

On March 17, 2016, Petitioner was carrying material to assemble boxes with a co-worker. She tripped on a pallet and she fell onto a pallet; as she fell, she landed on her shoulder. She felt immediate pain in her shoulder. She reported the accident to "Yolanda." She continued to work until the end of her shift. She asked to be sent to the company clinic and she was sent to Midwest Orthopedics at Rush-Occupational Health Clinic.

At Midwest Orthopedics at Rush-Occ. Health, Petitioner was seen by Dr. Vlahos. The history was that the patient fell and injured her right wrist, shoulder and elbow. The severity of pain was said to be worse in the wrist, then elbow, then shoulder and minimal pain was noted in the hip. X-rays were said to be normal. The diagnosis was: contusions of the right shoulder, right elbow, right wrist and right hip. PT and medications were recommended and Petitioner was given restrictions regarding work activities and was provided with a wrist wrap. (PX 1, RX 5) She continued to work for Respondent for three more days. Thereafter, she requested a new assignment, which was declined by Respondent because she had work restrictions.

Petitioner continued treatment with Midwest Ortho-Occ. Health until May 12, 2016. She was given work restrictions which Respondent did not accommodate during this time. Back complaints were noted at the March 21, 2016 follow-up visit and the additional diagnosis of sprain of ligaments of lumbar spine was made. Petitioner had PT at Athletico from April 11, 2016 to May 17, 2016. On April 26, 2016, Dr. Rodarte noted a lack of congruence between Petitioner's stated level of pain and her ability demonstrated on exam. On May 4, 2016, ongoing right shoulder and right hip pain complaints were noted. The back and right hip exam was benign at that time. It was noted Petitioner was seen by 2 physicians and a PA-C during her treatment at Midwest, and it is charted that she was not pleased with the continuity of care. On May 12, 2016, Dr. Vlahos discharged Petitioner from care and she was advised to seek treatment with an orthopedic surgeon for her right shoulder and right hip. She was given the names of Drs. Nho, Blomgren and Bush-Joseph as possible referrals. Work restrictions of 30 pounds lifting, no constant far-reaching, and no overhead work were continued. (PX 1)

Petitioner next sought treatment with Dr. John O'Keefe, an orthopedic surgeon, beginning on May 31, 2016. While Petitioner's testimony implied that Midwest referred Petitioner to Dr. O'Keefe, this is not reflected in his records. Indeed, while "Referring Physician" is blank on what appears to be the initial intake document, Petitioner's attorney's name, phone number and fax number are set forth above the blank area on the same document. (PX 3)

Dr. O'Keefe's diagnosis was: "Severe sprain of right shoulder with intense weakness and tear like symptoms; Right leg sciatica intensely tender producing increasing (ascending?) radiculopathy. Dr. O'Keefe charted his impression as: 1.) Severe sprain of right shoulder with rotator cuff tear and anterior

capsular tear, probably SLAP lesion; 2.) Discal injury in the L/S with right sciatica and persistent weakness and pain; 3.) Heavy contusion of right hip. Petitioner was taken off work, prescribed therapy and medications. (PX 3)

At Petitioner's appointment on June 9, 2016, Dr. O'Keefe ordered a MRI of Petitioner's right shoulder and Petitioner continued to be off work. On July 7, 2016, Dr. O'Keefe ordered a MRI for Petitioner's lumbar spine and opinioned that Petitioner was likely suffering from a rotator cuff tear that required arthroscopic surgery. (P X 3)Petitioner continued to be kept off work. Petitioner was also referred by Dr. O'Keefe for Physical Therapy at Chicago Injury Specialists beginning on July 8, 2016. (PX 6)

Petitioner continued to treat with Dr. O'Keefe and MRIs for the Lumbar Spine and Right Shoulder were performed on August 1, 2016. The MRI of the Lumbar Spine revealed multiple disc bulges and the MRI of the Right Shoulder revealed subscapularis thickening from chronic tendinopathy. (PX 5) Dr. O'Keefe described the shoulder MRI results as abnormal and consistent with a non-displaced tear along with anterior and cephalad capsular sprain. (PX 3) Petitioner continued to be kept off work and Dr. O'Keefe ordered her to have an EMG performed. (PX 3)

On August 31, 2016, Petitioner was sent by Respondent for an independent medical examination (IME) with Dr. Jesse Butler. (RX 3, RX 4) Dr. Butler's diagnosis for the Petitioner was a lumbar strain and symptom magnification. Dr. Butler opined that Petitioner did not require additional treatment with respect to her lumbar spine. (RX 3). Dr. Butler did agree that Petitioner's treatment including physical therapy and medical management where reasonable and medically necessary up to the point of the IME on August 31, 2016. (RX 4) Dr. Butler's examination was limited to Petitioner's low back injury and he did not examine or have an opinion regarding Petitioner's right shoulder or right arm injuries. (RX 4) The mechanism of injury described by the patient was a reasonable cause for a lumbar strain. There were no contraindications to a return to work at full duty regarding the low back. Dr. Butler did not review the MRI imaging. Further, Dr. Butler testified that he did not provide an opinion of whether or not Petitioner was at MMI with respect to her right shoulder injury or other body parts beyond the low back. (RX 4)

At Petitioner's follow up appointment on September 13, 2016, Dr. O'Keefe recommended arthroscopic surgery for Petitioner's right shoulder and referred Petitioner for pain management. (PX 3) On October 4, 2016, Dr. O'Keefe again expressed the need for Petitioner to have shoulder surgery and recommended the Petitioner should have an independent medical examination with respect to her right shoulder. (PX 3). Dr. O'Keefe noted that Petitioner's EMG performed on September 2, 2016, was positive for right L4-5 radiculopathy. (PX 3) Petitioner continued to be taken off work. (PX 3) Dr. O'Keefe again expressed his concerns regarding Petitioner's right shoulder during follow up appointments on November 3, 2016, December 1, 2016, December 12, 2016, January 10, 2017, and February 14, 2017. He documented the suggestion of an IME. (PX 3) Further, Petitioner underwent another MR Arthrogram for her Right Shoulder on January 24, 2017, and Dr. O'Keefe noted the results suggested undersurface tearing and non-displaced tearing in the anterior capsule. (PX 5, PX 3)

Pursuant to Dr. O'Keefe's referral for management on September 15, 2016, Petitioner had an appointment from Dr. Abdellatif at ProClinics and was treated for her pain symptoms. (PX 7) Petitioner had follow up appointments with Dr. Abdellatif on four additional occasions with the last occurring on February 2, 2017. At the recommendation of Dr. Abdellatif, Petitioner underwent a series of epidural steroid injections, trigger point injections and diagnostic procedures on three separate occasions, September 21, 2016, October 7, 2016, and October 26, 2016. (PX 10)

Due to her persistent symptoms, Petitioner was referred by Dr. O'Keefe for a consultation with Dr. Salehi, a spine surgeon, on January 23, 2017. (PX 11). After his examination and review of records, Dr. Salehi opined that Petitioner would not need surgery, but would need further therapy for her low back pain. (PX 11)

Dr. O'Keefe released Petitioner to return to work with restrictions, effective February 14, 2017. Petitioner found work with a landscaping company starting March 1, 2017. She picks up papers and debris and is able to work within Dr. O'Keefe's restrictions, although they are not really shown in the records. Petitioner did not recall the exact restrictions. She makes $8.25 per hour at this job and she works less hours than at the job for Respondent.

Petitioner's low back continues to hurt her. She has right hip and right leg pain. Her right shoulder continues to hurt. She would like to have the surgery that has been recommended by Dr. O'Keefe. The last visit with Dr. O'Keefe was on February 14, 2017.

Respondent stopped paying TTD benefits after the Dr. Butler exam. Respondent did not provide proof of its compliance with Rule 9110.70(b) (7110.70). The last payment of TTD was on September 8, 2016. Respondent paid 22 weeks in TTD, for the time period of March 31, 2016 through September 8, 2016. (RX 2) Petitioner filed a Penalty Petition on the date of trial. (PX 12) Respondent filed its Reply, per leave granted by the Arbitrator. (RX 6)

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 her injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989) To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 205 (2003) 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 (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the ciurse of her employment by Respondent on March 17, 2016 based upon the unrebutted testimony of Petitioner and the medical records.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner gave Respondent timely notice, in accordance with §6 of the Act. Petitioner's unrebutted testimony was that she reported the injury to Yolanda on the day of accident and was sent to Respondent's clinic at the end of the day.

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

The Arbitrator finds that Petitioner's current condition of ill-being regarding her low back (lumbar strain and symptom magnification, at MMI as of 8/31/2016, per the report and deposition testimony of Dr. Butler) is causally related to the injury. Any complaints, symptoms, or treatment regarding the low back after 8/31/2016 is not causally related to the injury, based upon the persuasive opinions of Dr. Butler and the records of Midwest Orthopedics at Rush Occ. Health, which document benign low back and hip exams on May 4, 2016 and Dr. Rodarte's documentation of a lack of congruence between Petitioner's stated level of pain and her ability demonstrated on exam on April 26, 2016.

The Arbitrator finds that Petitioner's right shoulder condition (right shoulder rotator cuff tear) is causally related to the injury, based upon Petitioner's testimony and the medical records. Respondent did not obtain an IME regarding Petitioner's right shoulder, so Dr. O'Keefe's opinions and findings are unrebutted.

WITH RESPECT TO ISSUE (G), WHAT WERE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's unrebutted testimony establishes that the AWW was $330.00.

WITH RESPECT TO ISSUE (H), WHAT WAS PETITIONER'S AGE, MARITAL STATUS AND NUMBER OF DEPENDANTS AT THE TIME OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's unrebutted testimony was that she was born on 11/10/1967. The medical records confirm this date of birth. Petitioner was 48 years old on the date of accident.

Petitioner's unrebutted testimony establishes that she was unmarried and had one dependent child under the age of 18 on the date of 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:

Based upon the Arbitrator's findings above regarding accident and causation, the treatment rendered to Petitioner through August 31, 2016 is causally related to the injury and is found to be reasonable and necessary to cure or relieve the effects of the injuries. These expenses will be awarded.

Treatment regarding the low back after August 31, 2016 is found to be not causally related to the injury and is not reasonable and necessary. These expenses will not be awarded.

Treatment regarding the right shoulder after August 31, 2016 is found to be causally related to the injury and is reasonable and necessary. These expenses will be awarded.

The awarded medical expenses are as follows:

Provider	Dates of Service	Balance
ATI Physical Therapy	04/11/16 to 5/17/16	$ 3,083.52
Marian Orthopedic Rehab	05/31/16 to 02/14/17	$21,981.34
Advanced Rx Management	05/31/20 & 07/07/16	$ 1,610.44
MRI Lincoln Imaging	06/23/16 to 01/24/17	$ 5,297.00
Chicago Injury Specialists	7/8/2016 to 7/20/16	$ 820.00
Total Bills Awarded:		**$32,792.30**

Respondent is entitled to a credit for all bills that it has paid. This award is made pursuant to §§8(a) and 8.2 of the Act.

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

Given the proofs in this case and the Arbitrator's findings above regarding accident and causation, above, the Arbitrator finds that Petitioner is entitled to prospective medical care as offered by Dr. O'Keefe regarding her right shoulder, to wit: Right shoulder scope with probable open repair of rotator cuff tear, along with all related services and treatment. Respondent is ordered to authorize and pay for same, in accordance with §8(a) of the Act.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Given the proofs in this case and the Arbitrator's findings regarding accident and causation, above, Petitioner is entitled to the claimed TTD from 9/9/2016 to 3/1/2107 (24-5/7 weeks), as requested on the

Request For Hearing form. (ArbX 1) Petitioner made no claim for TTD prior to 9/9/2016 and none will be awarded for this time period. The evidence establishes that Petitioner was not at MMI regarding her right shoulder (awaiting the recommended surgery) after 9/8/2016 and was thus entitled to TTD benefits pursuant to Interstate Scaffolding v. Illinois Workers' Compensation Commission, 236 Ill.2d 132 (2010) until March 1, 2017, when she began new employment, making the same wage as she was on the date of accident.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The filing of the Petition for Penalties and Attorney's Fees on the day of trial does leave the Arbitrator in a difficult situation, as the Parties were otherwise ready for trial on a §19(b)/8(a) basis. The solution that the Arbitrator proposed was to allow Respondent leave to file its Reply as RX 6, after proofs were closed. The Parties agreed with this proposal. Per the Reply, Respondent did receive a written demand for payment of benefits in august of 2016.

Considering Petitioner's Petition, Respondent's Reply and the evidence adduced, the Arbitrator awards the following on the issues of penalties and attorney's fees.

§19(l) penalties for non-payment of TTD and failure to comply with Rule 7110.70(b), 173 days times $30.00/day = **$5,190.00.**

§19(k) penalties for non-payment of TTD (Unreasonable delay or refusal to pay TTD without any basis to dispute Dr. O'Keefe's ongoing right shoulder treatment and disabling Petitioner from work), **$3,126.32** (50% of the $6,252.64 in TTD benefits awarded).

§19(k) penalties for non-payment of medical expenses (Failure to pay shoulder related bills from Marion Orthopedics and MRI Lincoln Imaging without any basis, and failure to pay bills for back related treatment that Dr. Butler endorsed), **$16,396.15** (50% of the awarded medical expenses).

§16 attorney's fees based upon §19(k) awards for unpaid TTD and medical expenses, **$3,904.49.**

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

Loretta Haynes,

Petitioner,

vs. NO: 15WC035551

State of Illinois/Southern Illinois University- Edwardsville

18IWCC0173

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, permanent disability, 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 2, 2017 is hereby affirmed and adopted.

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

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

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: MAR 22 2018
SJM/sj
o-3/8/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAYNES, LORETTA
Employee/Petitioner

Case# **15WC035551**

18IWCC0173

ST OF IL/SIU-EDWARDSVILLE
Employer/Respondent

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

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

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

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

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

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

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

JUN 2 - 2017

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

18IWCC0173

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

Loretta Haynes
Employee/Petitioner

v.

State of Illinois/SIU - Edwardsville
Employer/Respondent

Case # 15 WC 35551

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 28, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 7, 2015,** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being **in the right little finger and right hand** *is* causally related to the accident, but Petitioner's condition of ill-being **in the right shoulder, right knee, right hip, back or neck** *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$24,494.40**; the average weekly wage was **$471.05.**

On the date of accident, Petitioner was **62** years of age, ***single*** with **1** dependent child.

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

ORDER

Respondent shall pay Petitioner the sum of **$282.63/week** for a period of **18.675** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **7.5% loss of use of the right hand and 15% loss of use of the right little finger.**

Respondent shall pay all reasonable and necessary medical services for Petitioner's **right little finger and right hand as contained in Petitioner's Exhibit 1,** as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses **for treatment rendered to Petitioner's right little finger and right hand** directly to the provider. Respondent shall pay any unpaid, related medical expenses **for treatment rendered to Petitioner's right little finger and right hand** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit **for all benefits paid through group insurance** 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.

Melinda M. Pope-Sullivan

Signature of Arbitrator

6/1/17

Date

JUN 2 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Loretta Haynes
Employee/Petitioner

Case # 15 WC 35551

v.

Consolidated cases: N/A

State of Illinois/SIU - Edwardsville
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The evidence reflects that Petitioner was employed by Southern Illinois University as a teacher's assistant on October 7, 2015. On that date while participating in an evacuation drill, Petitioner fell off the back of a school bus from a seated position onto her right hand and side. Despite some differences in the details of the fall, Petitioner's testimony was largely corroborated by the testimony of Petitioner's co-workers Yvonne Jeffries and Novia Banks.

As to her current condition, Petitioner testified that her right little finger has a little bit of motion, but not like the one on her left hand where she can touch her palm. She testified that she still has some pain, but that it was not severe like it was before. She testified that she is able to write and can do normal holding of things, but that heavy lifting is a problem. She testified that her fractured finger is unable to be flattened out and that it stays bent. She testified that her right wrist is better but that she still has some pain. She testified that the range of motion in both of her wrists is not the same and that she feels some stiffness and does exercises to get it loose. She testified that she can lift more with her left wrist and that she tends to do less lifting with the right hand.

Petitioner testified that as to her right shoulder, she still has pain and cannot force it to reach. She testified that she still has some stiffness and that she tries to force it in order to get better range of motion. She testified that she does her home exercise program every day and squeezes a ball. She testified that the soreness in her right hip has decreased and that her hip is pretty much back to where it was before the accident. She testified that her low back much better and that the injections helped tremendously.

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 Anderson Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on October 7, 2015, at which time it was noted that she presented with a right hand injury after she had an evacuation drill when she fell off a bus causing injury to her right hand. It was noted that Petitioner had point tenderness with mild swelling and bruising to the proximal aspect of her right fifth finger with decreased range of motion secondary to pain and inflammation. It was noted in the Triage Notes that Petitioner complained of right hand pain with a superficial skin tear at the right palmar 5th PIP joint. It was noted that x-rays of the right hand that were performed were interpreted as revealing a tiny triangular osseous fragment at the medial base of the fifth middle phalanx which may represent a non-displaced fracture; recommend clinical correlation for

tenderness at this site. The clinical impression was noted to be that of a right finger fracture and Petitioner was given a right knuckle orthosis DME splint. (PX3).

The records of Anderson Hospital reflect that Petitioner underwent x-rays of the fifth right finger on February 1, 2016, which were interpreted as revealing (1) interval healing in essentially anatomic alignment of the tiny volar avulsion fracture at the base of the right fifth middle phalanx; (2) mild polyarticular osteoarthritis. (PX3).

The medical records of Dr. Jason Barnett/Jamie Ott, FNP, Anderson Medical Group, were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on October 13, 2015, at which time it was noted that she was involved in a fall injury from a bus during a safety drill on October 7, 2015. It was noted that Petitioner was assisting children learning how to get out of the back door of the bus, that she noted no problems until she lost her footing and fell out of the back door of the bus and landed on the pavement on her right side. It was noted that Petitioner stated that she got up and noticed she had some pain in her right hand/wrist and went to Anderson Hospital for medical care. It was noted that Petitioner stated the rest of the her hand and wrist were tender from the fall, that she had no complaints of pain in the elbow or shoulder and that she complained of pain in her right side. The impression was noted to be that of a fracture of the right hand fifth finger. It was noted that Petitioner wanted to see orthopedics and a referral was given. Petitioner was instructed to take medications and wear the splint as directed. (PX4).

The records of Dr. Barnett reflect that Petitioner was seen on October 20, 2015, at which time it was noted that she was experiencing decreased mobility, swelling and tenderness. It was noted that Petitioner stated that she continued to have some pain in the right side of the abdomen and that it was sharp and stabbing at times. It was noted that Petitioner had some pain in the right knee, that no discoloration was noted, that no gross deformity was noted, that she had good range of motion and that no limping was noted. It was noted that the assessment was that of hand fracture, right, with routine healing. It was noted that Petitioner stated that her orthopedic physician had ordered physical therapy. At the time of the November 3, 2015 visit, it was noted that Petitioner continued to have pain in her right hand involving the fifth finger fracture and that her physical therapy had been slow because of the pain she was experiencing. It was noted that Petitioner continued to have pain in her right rib area and that she stated that the area did not always hurt but that she had pain with movement, rest and doing various activities of daily living. The assessment was noted to be that of right hand fracture with routine healing. Petitioner was instructed to continue with her orthopedist and physical therapy. As to the right upper quadrant pain, Petitioner was instructed to continue to monitor the area. (PX4).

The records of Dr. Barnett reflect that Petitioner was seen on December 17, 2015, at which time it was noted that she presented concerning some abdominal pain she was having intermittently in the right upper abdomen. It was noted that Petitioner stated that she had a past history of kidney stones and that the area was examined with no skin discoloration, no deformity and no pain with palpation. It was also noted that Petitioner had a headache and that the locations affected included the occipital, and that her symptoms were associated with stress. The assessment was noted to be that of right-sided abdominal pain and intractable headache, unspecified chronicity pattern. At the time of the January 14, 2016 visit, it was noted that Petitioner was seen for follow-up of right hand pain. It was noted that Petitioner reported that she had been making improvements in range of motion and pain with exercises given to her by her chiropractors. It was noted that Petitioner had seen Dr. Burton, a hand specialist in Belleville, and that she was not happy with his treatment plan and requested a new referral. It was noted that Petitioner was also seen for follow-up on hypertension, hyperlipidemia and anxiety. It was noted that Petitioner was given a plastic surgery consult referral. (PX4).

The medical records of Dr. Nathan Mall were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on October 16, 2015 for a chief

complaint of right hand, wrist and forearm pain. It was noted that Petitioner stated that they were on an evacuation drill off a bus, that they were lifting kids out of the back of the bus and that the teachers had to jump off the back. It was noted that Petitioner fell off and injured her right hand and wrist, and that she had pain in the small finger and soreness in her wrist. The assessment was noted to be that of right wrist sprain and possible fracture of the small finger ray. Petitioner was recommended to undergo physical therapy for wrist range of motion and strengthening and to use an ulnar gutter splint. At the time of the November 6, 2015 visit, it was noted that Petitioner thought that she was only allowed to see Dr. Mall for her hand and wrist, but that she was having other symptoms. It was noted that Petitioner did not bring those up at her first visit and that she reported that she had been having neck pain, lumbar spine pain, shoulder pain on the right, knee pain and hip pain on the right after her work accident of October 7, 2015. It was noted that Petitioner stated that she landed on her right knee as well as onto her right hand and wrist. It was noted that Petitioner stated that she had been seen on a regular basis by a chiropractor for her lumbar spine but not for her neck, and that she had been seen approximately two years ago for her right knee but had not had any treatment for the past two years. The assessment was noted to be that of (1) right wrist sprain, possible ligament injury; (2) right hand metacarpal fracture; (3) cervical strain, possible disk injury; (4) lumbar strain, possible disk injury; (5) right knee possible meniscus tear; (6) right hip pain, trochanteric bursitis, possible lumbar spine origin. Petitioner was recommended to see a hand therapist for an ulnar gutter splint and to start physical therapy for her right shoulder, right knee, right hip, lumbar spine and neck. Petitioner was recommended to take a Medrol Dosepak and anti-inflammatory medications and to undergo x-rays and a cortisone injection in the right knee. The injection was performed on that date. It was noted that Petitioner was also to get an MRI arthrogram of her right wrist to evaluate for a scapholunate injury given her pain in this location in addition to her pain over the small finger. Petitioner was referred to Dr. Gornet for her cervical and lumbar issues. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on November 17, 2015, at which time it was noted that she had pain to palpation over the metacarpals ulnarly, that she continued to have pain over the radioscaphoid joint, that she had pain over the AC joint, pain with rotator cuff testing and pain with O'Brien's testing that had diminished somewhat from her last visit, that her right knee pain was substantially improved and that she had better range of motion and less swelling. The assessment was noted to be that of (1) right hand injury/fracture; (2) right wrist sprain, possible ligament injury; (3) lumbar strain, possible disk injury; (4) cervical strain, possible disk injury; (5) right shoulder AC arthrosis, biceps tendinitis and rotator cuff tendinitis; (6) right knee possible meniscus tear with underlying osteoarthritis; (7) right hip trochanteric bursitis possible lumbar spine origin. Petitioner was recommended to undergo additional therapy with the hand. It was noted that she was doing well from the knee standpoint and that physical therapy for the knee, shoulder, hip and cervical and lumbar spines was recommended. At the time of the December 1, 2015 visit, it was noted that Petitioner stated that her shoulder pain had improved, that her hip pain was improving, that she continued to have pain in the hand and wrist of the right hand and that the right knee also continued to bother her somewhat but she was doing somewhat better with it. The assessment was noted to be that of (1) right hand fifth ray fracture; (2) right hand TFCC tear and scapholunate tear, based on MRI; (3) lumbar strain, possible disc injury; (4) cervical strain, possible disc injury; (5) right shoulder AC joint arthrosis, biceps tendinitis, rotator cuff tendinitis, improved; (6) right knee possible meniscus tear with underlying osteoarthritis; (7) right hip trochanteric bursitis, possible lumbar spine region, improved. Petitioner was recommended to undergo physical therapy for the hand and wrist and to see Dr. Mirly for the TFCC and scapholunate injuries for potential risk of arthroscopy versus conservative treatment. It was noted that Petitioner was recommended continued physical therapy for the knee, shoulder, and hip as well as her lumbar and cervical spine. Petitioner was also recommended to see Dr. Gornet for her lumbar and cervical spine for evaluation and treatment. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on December 29, 2015, at which time it was noted that she stated that her hip had flared up again and that she had been limping recently. It was

noted that Petitioner had seen Dr. Gornet and was going to be undergoing some injections. It was noted that Petitioner stated that the knee was doing better after the injection, that the right shoulder was still achy but was doing much better and that she was going to see Dr. Burton for her hand and wrist injuries, but that her therapy was going well and that she was regaining a substantial amount of motion. The assessment was noted to be that of (1) right hand fifth ray fracture; (2) right wrist TFCC tear and scapholunate tear; (3) lumbar strain; (4) cervical strain; (5) right shoulder AC arthrosis, biceps tendinitis, rotator cuff tendinitis; (6) right knee possible meniscus tear with underlying osteoarthritis; (7) right hip trochanteric bursitis, possible lumbar spine origin. Petitioner was recommended physical therapy for her wrist and hand and it was noted that she would see Dr. Burton for the TFCC and scapholunate injuries. Petitioner was recommended to continue her shoulder exercises and knee exercises at home and that she follow up with Dr. Gornet for her cervical and lumbar injuries. At the time of the March 1, 2016 visit, it was noted that Petitioner had seen the hand surgeon for her TFCC tear, that she had seen Dr. Blake for injections into her back and that she continued to have pain in her right shoulder as well as on the right knee. The assessment was noted to be that of (1) right shoulder biceps tendinitis and AC joint arthrosis with rotator cuff tendinitis and impingement; (2) right knee possible meniscus tear. Petitioner was recommended to undergo MRIs of her knee and shoulder. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on March 29, 2016, at which time it was noted that she had been having significant problems with her right shoulder and right knee since her work accident. It was noted that Petitioner had been getting somewhat better recently with the prior conservative treatment for these conditions. The assessment was noted to be that of (1) right shoulder biceps tendinitis and AC joint arthrosis with acute extension of her rotator cuff tear from the supraspinatus into the infraspinatus and upper border of the subscapularis; (2) right knee lateral meniscus tear and patellofemoral osteoarthritis aggravation. It was noted that Dr. Mall did not recommend surgical intervention for her right shoulder and that functionally she was doing quite well and was quite happy with the status of her shoulder. It was noted that in terms of the right knee, Petitioner stated that she was diagnosed with a meniscal tear back in 2011 and that she had been doing pretty well before this, but that she was quite happy with the overall status of her knee at that point. Petitioner was placed at maximum medical improvement and was instructed to return as needed. (PX5).

The medical records of Dr. Chad Weber/Chiro-Med Ltd. were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner completed various paperwork on October 19, 2015, including a Worker's Compensation Questionnaire on which she indicated that she hurt her right hand pinky finger at work on October 7, 2015. Included within the medical records was a Utilization Review report dated January 11, 2016 which non-certified continued physical therapy for the wrist and hand. (PX6).

The records of Dr. Weber reflect that Petitioner was seen on October 20, 2015 for a chief complaint of right posterior wrist, right posterior hand, right anterior wrist and right anterior hand discomfort. It was noted that Petitioner also complained of a chief complaint of cervical, right cervical, upper thoracic, right cervical dorsal and right clavicular discomfort. The assessment was noted to be that of (1) work-related injury; (2) sprain/strain of the wrist; (3) sprain/strain of the hand; (4) cervical sprain/strain; (5) segmental dysfunction upper extremity; (6) cervical subluxation; (7) spasm of muscle. It was noted that Petitioner's progress was good. At the time of the October 21, 2015 visit, no changes were noted in the chief complaints. At the time of the October 23, 2015 visit, no changes were noted in the chief complaints. At the time of the October 26, 2015 visit, no changes were noted in the chief complaints. At the time of the October 28, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner had been showing steady improvement since her treatment began. (PX6).

The records of Dr. Weber reflect that Petitioner was seen on November 2, 2015, at which time no changes were noted in the chief complaints. It was noted that Petitioner stated that she was still feeling a lot of pain at times, even when she wore her brace. It was noted that Petitioner was still having pain but

that it was not as consistent as it had been. At the time of the November 4, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner was doing slightly better on that date. At the time of the November 6, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner was compliant with her activities of daily living and continued to ice as directed. At the time of the November 9, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner had to receive a new splint for her hand and wrist so that they made her squeeze things and that it was a little more sore on that date. It was noted that Petitioner had a slight regression in her wrist due to movements on that date. At the time of the November 11, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner stated that she was doing better with the new splint and that she was feeling better. At the time of the November 13, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner had been doing better and had an MRI of her wrist scheduled for the following week. (PX6).

The records of Dr. Weber reflect that Petitioner was seen on November 16, 2015, at which time no changes were noted in the chief complaints. It was noted that Petitioner had been doing better but did have a little bit of throbbing in her wrist. At the time of the November 18, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner was doing slightly better but was still having pain in her wrist especially with activity. At the time of the November 20, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner was gradually seeing improvement but was still having a very hard time operating her right hand. It was noted that Petitioner had been showing improvement in her subjective and objective findings and that she was still having motor issues with the left [*sic*] hand and wrist. At the time of the November 23, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner had been doing better but that her hand hurt more without the brace on. At the time of the November 25, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner had been doing well with her home exercise programs and had been icing as instructed. It was noted that Petitioner was still not having good mobility of her right pinky finger. At the time of the November 30, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner had been having a rough day and that she was feeling a slight increase in pain. It was noted that Petitioner was going to see Dr. Mall for an evaluation of her wrist and the results of her MRI. (PX6).

The records of Dr. Weber reflect that Petitioner was seen on December 4, 2015, at which time no changes were noted in the chief complaints. It was noted that Petitioner reported that she had been having pain in her fifth finger, that she met with Dr. Mall and it was discovered that she had torn ligaments in her wrist and that she was given new orders for therapy. At the time of the December 7, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner also complained of right anterior knee and right posterior knee discomfort and that the onset of pain was sudden and first noticed on October 7, 2015. Petitioner also reported lumbar and right sacroiliac discomfort on that date and that the onset of pain was sudden and first noticed on October 7, 2015. The assessment was noted to be that of (1) work-related injury; (2) sprain/strain of the wrist; (3) sprain/strain of the hand; (4) cervical sprain/strain; (5) subluxation of lumbar; (6) segmental dysfunction lower extremity; (7) segmental dysfunction upper extremity; (8) cervical subluxation; (9) patellar tendinitis; (1) spasm of muscle. It was noted that Petitioner's prognosis was good. It was noted that Dr. Mall had ordered physical therapy to begin on Petitioner's knee, which began on that date. At the time of the December 9, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner found it difficult to stand and that she had been about the same since last seen. (PX6).

The records of Dr. Weber reflect that Petitioner was seen on December 11, 2015, at which time no changes were noted in the chief complaints. It was noted that Petitioner had been about the same since she was last seen. It was noted that Petitioner was scheduled to see Dr. Gornet on December 21st for another MRI and evaluation. At the time of the December 14, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner reported that she was gradually doing better and had been

working on her home exercise programs at home. It was noted that Petitioner was having less actual pain, but was still very achy. At the time of the December 16, 2015 visit, no changes were noted in the chief complaints. Petitioner had been doing slightly better and reported that she was only having achiness in her hand and wrist on that date. At the time of the December 18, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner had been feeling better in her wrist and neck areas and that she had been working on her home exercise programs at home. At the time of the December 22, 2015 visit, no changes were noted in the chief complaints. It was again noted that Petitioner had been feeling better in her wrist and neck areas and that she had been working on her home exercise programs at home. (PX6).

The records of Dr. Weber reflect that Petitioner was seen on December 23, 2015, at which time no changes were noted in the chief complaints. It was noted that Petitioner reported that she had been working on her hand and wrist strengthening exercises at home and that she did not have any increased pain afterwards, but that it was a bit uncomfortable while performing them. At the time of the December 28, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner found it difficult to stand. At the time of the December 29, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner found it difficult to stand. At the time of the December 30, 2015 visit, no changes were noted in the chief complaints. It was noted that Petitioner found it difficult to stand. At the time of the January 4, 2016 visit, no changes were noted in the chief complaints. It was noted that Petitioner reported that she was feeling better with all of her areas of concern, that she had been doing all of her at-home care and that she stated that she felt a bit overwhelmed at times due to all of the different regions that she was working on. (PX6).

The records of Dr. Weber reflect that Petitioner was seen on January 8, 2016, at which time no changes were noted in the chief complaints. It was noted that Petitioner had been seen by the hand and wrist specialist and that they believed that she was doing well at that time. At the time of the January 11, 2016 visit, no changes were noted in the chief complaints. It was noted that Petitioner reported that she was feeling much better and was eager to get back to work. At the time of the January 15, 2106 visit, Petitioner returned for her "final case review." It was noted that Petitioner had reached maximum medical improvement and that her prognosis was good. (PX6).

The medical records of St. Luke's Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent x-rays of the right knee on November 6, 2015, which were interpreted as revealing osteoarthritis. (PX7).

The medical records of Radiology Consultants Midwest were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner underwent x-rays of the right hand on October 20, 2015, which were interpreted as revealing (1) base of thumb DJD; (2) no evidence of acute fracture; (3) DIPJ arthritis. (PX8).

The medical records of MRI Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner underwent an MRI arthrogram of the right wrist on November 17, 2015, which was interpreted as revealing (1) peripheral tear of the triangular fibrocartilage complex with intact extensor carpi ulnaris tendon; (2) questionable defect at the scapholunate ligament, though there is motion artifact, without widening or abnormal signal. The records reflect that Petitioner underwent an MRI of the cervical spine on December 21, 2015, which was interpreted as revealing (1) post-op interbody solid fusion C3 through C6; (2) moderate right paracentral disc herniation C2-3 with mild cord flattening and deformity but no abnormal cord signal or foraminal involvement; (3) advanced degenerative disc disease C6-7 without central stenosis but with right greater than left foraminal stenosis. An MRI of the lumbar spine performed on the same date was interpreted as revealing (1) mild grade I listhesis at L4-5 and L5-S1, probably due to facet arthropathy with associated disc herniations, resulting in a high degree of central spinal stenosis at L4-5 ad fairly high degree of

foraminal stenosis at both L4-5 and L5-S1; (2) bilateral disc herniations at L2-3 and L3-4, more prominent at L3-4 with foraminal stenosis and possible root impingement, more prominent at the L3-4 level. The records reflect that Petitioner underwent an MRI of the right shoulder on March 29, 2016, which was interpreted as revealing (1) large rotator cuff tear with retraction largely involving the supraspinatus tendon, but also partial tearing of the subscapularis and infraspinatus tendons; (2) 1 cm loose body seen medially within the subacromial/subdeltoid bursa; (3) advanced glenohumeral degenerative changes with degeneration of the labrum and advanced chondral thinning and subchondral change; (4) acromioclavicular arthropathy. An MRI of the right knee also performed on the same date was interpreted as revealing (1) abnormal lateral meniscus, largely due to previous trauma and surgery, though re-tear would be difficult to exclude given the amount of abnormal signal and configuration; (2) fairly advanced arthritic changes lateral compartment with a deep chondral fissure and possible chondral flap with subchondral changes in the medial compartment; (3) diffuse moderate patellofemoral degenerative changes. (PX9).

The medical records of Dr. Matthew Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner was seen on December 21, 2015, at which time it was noted that she presented with a chief complaint of low back pain to the right side, right buttock and right hip and down the right leg to her knee into her anterolateral calf. It was noted that Petitioner had significant neck pain in her right trapezius, right shoulder and down her right arm into her hand. It was noted that on October 7, 2015, Petitioner had jumped and fallen off the bus, landing on her right side and causing her injuries. It was noted that Petitioner essentially had not been able to return to work since then, was on restrictions and had two months of physical therapy. It was noted that Petitioner readily admitted to a history of neck pain in the past, that she had a multilevel spinal fusion done by Dr. Bailey and that she stated that she was doing well. It was noted that Petitioner also admitted to having low back pain in the past and that she had been treated on a regular basis by "Dr. Chad." It was noted that Petitioner felt that her symptoms were fairly severe and much worse than anything she had had prior to the fall, that her symptoms were constant, that her low back was made worse with bending or lifting, that her neck was worse with reaching, pulling or overhead work and that both were relieved by a neutral position. It was noted that Petitioner had right arm pain and right leg pain. It was noted that the working diagnosis was acute disc herniation at C2-3, acute disc herniation at C6-7 right, lateral disc herniation at L4-5 right, aggravation of preexisting facet arthropathy and spinal stenosis at L4-5 and what appeared to be aggravation of preexisting facet arthropathy at L5-S1 right and potentially a new disc herniation present there. Petitioner was recommended injections at L4-5 and L5-S1 right and an injection at C6-7 right. It was noted that Dr. Gornet wished to see her prior chiropractic notes. (PX10).

The records of Dr. Gornet reflect that Petitioner was seen on May 16, 2016, at which time it was noted that she brought her IME report. No physical examination-related notations were made in the office note. At the time of the August 18, 2016 visit, it was noted that Petitioner was still having a low level of neck and low back pain, but that it was tolerable for her. It was noted that Dr. Gornet placed Petitioner at maximum medical improvement and did not anticipate any further significant treatment. It was noted that Petitioner was at full duty and was tolerating her symptoms well. Petitioner was instructed to return as needed. At the time of the February 16, 2017 visit, it was noted that Petitioner still had some neck and low back pain. It was noted that Petitioner was working full duty. It was noted that Petitioner had "open medical" and that she had had no new slips, falls or other trauma. No physical examination-related notations were made in the office note. It was noted that the next follow-up was in six months. (PX10).

The medical records of Dr. Timothy Burton were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The records reflect that Petitioner was seen on January 6, 2016, at which time it was noted that back in October she fell off of the bus while working. It was noted that Petitioner fell onto an outstretched right hand and wrist and stated that since then she had had some pain. It was noted

that Petitioner stated initially she was diagnosed with a non-displaced fracture involving the small finger and underwent a period of immobilization. It was noted that going forward, Petitioner continued to have pain and stiffness and that an MRI arthrogram was performed, revealing a partial tear of the TFCC. It was noted that Petitioner's more recent complaints involved resolving stiffness with the right small finger but the inability to fully extend and flex the small finger, that the swelling that was once present had resolved and that she sometimes had pain when she bumped the small finger. The assessment was noted to be that of hand joint stiffness. It was noted that Petitioner was virtually asymptomatic as it pertained to her wrist and her distal radial ulnar joint, and that the peripheral tear could have been the result of the fall while working but that the signs could be related to previous trauma. It was noted that Petitioner's biggest complaint was stiffness involving the small finger and that she stated that her stiffness was resolving with therapy. It was noted that Petitioner could work with no restrictions as it pertained to her right hand. (PX11).

The medical records of Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The records reflect that Petitioner underwent x-rays of the right wrist and hand on January 6, 2016, both of which were interpreted as normal. (PX12).

The medical records of Pain and Rehabilitation Specialists of St. Louis were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. Petitioner underwent right L4-L5 ILESI with fluoroscopy on January 12, 2016 for a pre- and post-operative diagnosis of right lumbar radiculopathy. Petitioner also underwent right L4-L5 ILESI with fluoroscopy on January26, 2016 for a pre- and post-operative diagnosis of right lumbar radiculopathy. Petitioner underwent right C6-C7 ILESI with fluoroscopy on February 9, 2016 for a pre- and post-operative diagnosis of right cervical radiculopathy. (PX13).

The medical records of Orthopedic Ambulatory Surgery Center of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The records related to the procedures performed by Dr. Blake on February 9, 2016, January 26, 2016 and January 12, 2016 as referenced in Petitioner's Exhibit 13. (PX14).

The medical records of Dr. Michael Beatty were entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The records reflect that Petitioner was seen on February 1, 2016 for an injury to the right hand. Petitioner was recommended to undergo x-rays and to use a buddy splint. On February 2, 2016, it was noted that the radiologist opined that there was partial dislocation to the collateral ligament, for which Petitioner was recommended to use a buddy splint in work activity. On February 3, 2016, it was noted that Dr. Beatty reevaluated the films and that he saw a fracture at the volar plate area on the index that was still evident. Petitioner was recommended to buddy splint and consider it a probable lower collateral ligament injury versus partial volar plate injury. Petitioner was instructed to return in two weeks. The September 21, 2016 letter directed to Petitioner's attorney pertained to the IME report of Dr. Williams. (PX15).

The Incident/Injury Reports were entered into evidence at the time of arbitration as Petitioner's Exhibit 16. The Report of Injury dated October 7, 2015 noted that Petitioner sat down and pushed herself off the back of a school bus during the evacuation drill and that upon landing, she fell forward and landed on her right hand causing her wrist to flex back and her palm to be cut. It was also noted that Petitioner's wrist and upper arm were throbbing down to her fingers. The Workers' Compensation Employee's Notice of Injury completed on October 26, 2015 noted that the body parts affected included that of the right hand, right shoulder, right knee, neck, back, right wrist and right pinky finger. The document was completed and signed by Petitioner. The Workers' Compensation Witness Report dated October 26, 2015 noted that the witnesses were that of Yvonne Jeffries and Novia Banks. (PX16).

The transcript of the deposition of Dr. Chad Weber was entered into evidence at the time of arbitration as Petitioner's Exhibit 17. Dr. Weber testified that he is a doctor of chiropractic, is a nationally board-certified chiropractor and is nationally board-certified in physical therapy. (PX17).

Dr. Weber testified that Petitioner had been his patient since the beginning of 2015 and that he treated her for a variety of complaints, including neck pain, discomfort and stiffness, sciatic pain shooting to her lower extremities, low back pain and knee pain. He testified that before Petitioner's work accident, her treatments included spinal decompression for her sciatic leg pain, mild tissue release, spinal adjustments to her cervical and lumbar spine and a variety of modalities, including electric stimulus and passive and active therapeutic exercises. He testified that on October 6, 2015, the specific areas of Petitioner's body that he treated included her neck, low back and left knee. (PX17).

Dr. Weber testified that when Petitioner returned on October 13, 2015 (which was a regularly-scheduled visit), her treatment plan was that of being seen two times per week. He testified that Petitioner reported that on October 7, 2015, she had slipped and fallen out of the back of the bus at work and that she had injured her hand. He testified that Petitioner told him that there was a fracture in it and that she was having pain over to her arm, and that she was having some increased issues with her neck. He testified that Petitioner had an exacerbation of how she was feeling, that the hand was very tender to the touch and that she seemed very distressed in her movement and activities. He testified that he did not document all of Petitioner's complaints related to her fall from the school bus because she was confident that the "work doctors" were going to take care of her situation. He testified that on October 19th they discussed the situation and indicated that they could not bill her private insurance for a work-related injury and that she seemed confused as to what her options were. He testified that Petitioner called back the next day and stated that she wanted him to do the therapy for her work-related injury. (PX17).

Dr. Weber testified that on October 20th as compared to her previous exams, Petitioner's range of motion in the cervical spine was reduced, her range of motion in the wrist was almost non-existent and extremely painful, that he found edema and swelling in the wrist and forearm as well as her cervical spine and top of her shoulder musculature and that she had muscle spasms in the wrist, forearm and neck. He testified that he diagnosed Petitioner with a sprain/strain of the right hand, sprain/strain of the right wrist, sprain/strain of the cervical spine, cervical subluxation, muscle spasm and edema. He testified that the significance of the fall and the mechanism of injury were significant not only to fracture her finger and injure her wrist, but also to exacerbate the symptoms of her cervical spine. He testified that it was his understanding that Petitioner was exiting the bus, that it sounded like she was being seated on the platform or exit of the bus and that she was scooting off and that she stumbled, falling onto her outstretched hand with her palm down, and that it jammed her forearm, arm and shoulder into her neck. He testified that it was his understanding that her right side seemed to take the brunt of her injury. (PX17).

Dr. Weber testified that after examining Petitioner on October 20, 2015, his recommendation for treatment was three times per week for the next 2-4 weeks depending on her response to therapy. He testified that he received two physical therapy scripts from Dr. Mall. He testified that he deferred to Petitioner's orthopedic doctors in terms of their diagnosis and causation opinions as well as their treatment recommendations for her. He testified that he last saw Petitioner on January 15, 2016 and that she was doing pretty well. He testified that Petitioner had some residual issues with the neck and the extremity, as well as the back and the knee. He testified that he believed she had reached maximum medical improvement and was released back to unrestricted duty at work. He testified that Petitioner has been on supportive care over the past year and that he has seen her approximately 10 times since she was released on January 15, 2016. (PX17).

Dr. Weber testified that he agreed with Dr. Williams that Petitioner suffered a fracture of her little finger and a contusion and sprain of her right hand and wrist that resolved as of January 22, 2016 when

she was released to return to work full duty. He testified that he disagreed with Dr. Williams' opinion that the injuries to Petitioner's shoulder and spine were preexisting problems that had no causal connection to and were not aggravated by the fall on October 7, 2015. He testified that he agreed with Dr. Williams' assertion that there were no findings specific to malingering or embellishing of Petitioner's symptoms. He testified that he agreed with Dr. Williams that Petitioner had an exacerbation of symptoms related to the fall which was a temporary worsening of pain. (PX17).

On cross examination, Dr. Weber testified that no one was disputing the fact that Petitioner had preexisting conditions before the injury at issue. He agreed that Petitioner reported on her registration form on March 13, 2015 that she had back pain. He agreed that his notations were similar in the October 6th and October 14th notes. He testified that he could have done a better job of notating the exacerbation of her symptoms. He testified that on October 20, 2015, Petitioner first reported cervical, right cervical, upper thoracic, right cervical dorsal and right clavicular discomfort. (PX17).

On cross examination when asked if he would agree that after reviewing all of the various medical records that Petitioner's complaints were consistent with her past medical history and documented complaints prior to October 7th, Dr. Weber responded that Petitioner had similar issues in the past with her neck and low back, but that the wrist and hand was a totally new situation that had never been documented that he was aware of. He testified that he agreed with Dr. Williams that Petitioner had problems with chronic low back pain and had seen a chiropractor since 2014 and that she had been seeing a chiropractor about twice a week prior to the fall in October. (PX17).

The transcript of the deposition of Dr. Nathan Mall was entered into evidence at the time of arbitration as Petitioner's Exhibit 18. Dr. Mall testified that he is an orthopedic surgeon and is board-certified in orthopedic surgery as well as in independent medical examinations. He testified that he is fellowship-trained in sports medicine and shoulder surgery and that he also sees many patients that have hip issues, ankle injuries, knee injuries and injuries to the elbow, wrist and hand. (PX18).

Dr. Mall testified that when he saw Petitioner on October 16, 2015, she explained to him that she was performing an evacuation drill off of a bus and that they were lifting kids out of the back of the bus and that the teachers then had to jump off the back. He testified that Petitioner reported that when she did this, she fell and landed on her right hand and wrist. He testified that his assessment was that of a right wrist sprain and possible fracture of the small finger. He testified that he recommended therapy for wrist range of motion and that she wear an ulnar gutter splint. He testified that he next saw Petitioner on November 6, 2015, at which time she stated that she thought she was only allowed to see him for her hand and wrist but that she was having other symptoms, including pain in her neck, lumbar spine, shoulder on the right, right knee and right hip. He testified that he recommended that Petitioner see the hand therapist for the ulnar gutter splints and make that more of a hand-based splint, that she start some physical therapy for her shoulder, knee, hip, lumbar spine and neck, and that she also use a steroid pack. He testified that he also recommended a cortisone injection into the knee to see if that would help improve any pain related to osteoarthritis or meniscus tear. (PX18).

Dr. Mall testified that when he saw Petitioner on November 17, 2015, she came in that day for a follow-up of her MRI of her wrist. He testified that he did not yet have the radiologist's report yet, so he recommended that she continue with physical therapy. He testified that on December 1, 2015, Petitioner's right shoulder had improved and her hip was improving. He testified that Petitioner continued to have pain in the hand and wrist of the right hand and that the right knee continued to bother her, but that she was doing better than prior to the injection. He testified that the MRI demonstrated a TFCC tear and a scapholunate tear in the right wrist. He testified that he recommended that Petitioner see a hand specialist and that he also recommended continued therapy for her finger as well as for her knee, shoulder and hip. He testified that he also recommended that Petitioner see Dr. Gornet for her lumbar and cervical spine. He testified that he next saw Petitioner on December 29, 2015, at which time she reported

that her hip had flared up on her again and that she had been limping. He testified that Petitioner stated that she had seen Dr. Gornet and was going to be undergoing some injections and that the knee was doing better. He testified that Petitioner reported that her shoulder was still a little achy but that she was doing better, and that she was going to be seeing Dr. Burton for her hand and wrist injuries. He testified that he recommended that Petitioner continue the physical therapy for her wrist and hand, that she continue to follow-up with Dr. Gornet for her cervical and lumbar problems and that if her shoulder and knee continued to be problematic, they would get additional imaging. (PX18).

Dr. Mall testified that he next saw Petitioner on March 1, 2016 and that an MRI had been ordered of the right knee and right shoulder as she had called in stating that she was still having symptoms. He testified that he discussed the MRI results with Petitioner. He testified that Petitioner stated that her shoulder was not bothering her to the point that she wanted to proceed with surgery. He testified that Petitioner indicated that she had been diagnosed with a meniscal tear in 2011, that she had been treating conservatively and that she wanted to try continued conservative treatment for the knee. He testified that this was the last time that he saw Petitioner, and that he released her back to full duty and placed her at maximum medical improvement. (PX18).

Dr. Mall testified that his diagnoses were that of a right wrist TFCC tear and a right wrist scapholunate tear, that she had a finger fracture on her right hand, that she had a right rotator cuff tear with a chronic component and an acute component and that she also had a right knee strain/contusion as well as right hip contusion. He testified that he deferred to Dr. Gornet regarding the spinal complaints. He testified that he believed that the fall that Petitioner described caused the right wrist injury, that her fall onto an outstretched arm was a classic injury mechanism for a rotator cuff injury and that falling and landing onto the hip and knee could cause contusions and bruises to those areas. He testified that he believed that the injury irritated and caused a bruise to Petitioner's knee as well, and that all of her injuries were caused, or at least the injuries contributed to, the development of symptoms in those areas. (PX18).

Dr. Mall testified that he disagreed with Dr. Williams' opinion that Petitioner suffered a fracture of her little finger and a contusion and sprain to the right wrist and hand, as her pain was localized to the two structures that they saw on the MRI that were actually injured. He testified that a fall from 3 or 4 feet out of the back of a bus could stir up inflammation in a knee and could significantly worsen the amount of synovitis in the knee. He testified that a fall onto an outstretched arm was a classic injury mechanism for a rotator cuff tear and even if it pre-existed the accident, it was likely that it was aggravated or irritated by the injury mechanism. He testified that for trochanteric bursitis, the most common thing that he saw people develop pain from was a fall. He testified that he agreed with Dr. Williams that he did not make any specific findings of malingering or embellishing of symptoms. (PX18).

On cross examination when asked of his conception of the accident, Dr. Mall testified that Petitioner was helping students off the back of the bus and that she fell off the back of the bus herself. He testified that he believed that Petitioner was standing at the time that she fell and then testified that he did not remember the exact details. He testified that the height from which she fell mattered and that a school bus was usually 3-4 feet up in the air. He testified that from what he understood, Petitioner's wrist hit the ground when she fell and then her knee, hip and right side of her body. He testified that from what he understood, Petitioner's wrist hit first and then she sort of fell onto her right side. (PX18).

On cross examination, Dr. Mall agreed that Petitioner did not mention complaints other than her finger and wrist because she thought he was seeing her in that capacity exclusively. He agreed that if he looked at the other medical records, there were some limited to essentially non-existent reporting of hip, knee and shoulder complaints and that her spinal complaints appeared to be fairly consistent with her prior treatment with Dr. Weber that pre-dated the accident. He testified that he did not have the opportunity to review Petitioner's prior cervical surgery notes, nor did he see anything about a right hip

fracture. He testified that he did not see the images of the prior MRI of the right knee or operative note addressing the medial and lateral meniscus tears. He further testified that he did not see the 2010 MRI of Petitioner's lumbar spine. (PX18).

On cross examination, Dr. Mall testified that he did not opine that Petitioner was a surgical candidate for the right knee. He testified that he recommended that Petitioner see a surgeon for her TFCC tear and scapholunate tear, but that he did not do that surgery. He testified that as to the right rotator cuff tear, they were able to resolve Petitioner's symptoms conservatively so he would not recommend surgery for her. (PX18).

On cross examination, Dr. Mall testified that as to Petitioner's finger fracture, it was probably not going to get any worse and that the stiffness that she had was probably something that she was going to have to live with. He testified that he did not place Petitioner at maximum medical improvement as to the right wrist and that that was going to be addressed by the physician to whom Petitioner was referred, and that the last time he examined her Petitioner was still having pain over the TFCC and the scapholunate. He testified that as to the right shoulder, he believed that Petitioner was capable of performing full duty work from a shoulder standpoint at the time that he released her. He testified that he made it clear to Petitioner that she could return if her shoulder condition worsened. He testified that as to the right hip, he would not suspect that Petitioner would have any further problems with her hip from the fall. He testified that Petitioner ambulated comfortably at the time that he released her. (PX18).

The CV of Dr. Nathan Mall was entered into evidence at the time of arbitration as Petitioner's Exhibit 19. The Tri-Star Authorizations dated November 12, 2015 were entered into evidence at the time of arbitration as Petitioner's Exhibit 20.

The transcript of the deposition of Dr. James Williams was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Williams testified that he is a physical medicine and rehabilitation specialist and is not a surgeon. He testified that he performed an IME, and that Petitioner stated that she had problems with pain in her right hand, her wrist, her arm, shoulder, knee, neck and low back, and that she reported that this was pain that came from the accident that she had on October 7, 2015. He testified that the examination performed was relatively normal, that Petitioner's complaints were fairly extensive and that her physical examination did not show any significant objective identifiable problems other than complaints of tenderness, which were her reports of pain with palpation. He testified that there was a mismatch between Petitioner's complaints and the physical examination. (RX1).

Dr. Williams testified that when he reviewed the extensive medical records, Petitioner clearly had a chronic pain problem that involved multiple musculoskeletal regions which pre-dated the injury at work on October 7, 2015. He testified that as for the incident in October of 2015, Petitioner had a fracture of her little finger and contusion and sprain of the right wrist and hand that were related to the work accident. He testified that Petitioner reached maximum medical improvement for the finger and wrist on January 22, 2016, which was the time that she was released to return to work full duty by Dr. Weber. He testified that he would not place any restrictions on Petitioner as it related to those conditions. (RX1).

Dr. Williams testified that he did not believe that Petitioner's complaints referable to her knee, shoulder and spine were related to the events in October of 2015 and that they were pre-existing problems and were longstanding. He testified that as Petitioner had zero impairment for the middle phalanx fracture as well as the right wrist sprain. (RX1).

On cross examination, Dr. Williams agreed that he did not perform surgery but that he made surgical referrals. He testified that he saw people both before and after surgery. He testified that the treatment types that he provided include prescribing medications, therapy, braces and prosthetics, and that he also provided education and helped people understand how to do the rehabilitation or do the things

they needed to do to get better. He testified that he rarely did joint injections because generally they were not indicated and that the scientific literature for most of the injections was fairly weak. (RX1).

On cross examination, Dr. Williams agreed that Petitioner suffered a mildly displaced fracture of the right fifth finger. He testified that a TFCC tear could be seen, but that it was unlikely to have occurred at the time of the fall. He testified that he did not recall specifically whether there was any documentation of wrist pain prior to the fall, but that she certainly had complaints of musculoskeletal pain in multiple regions. He agreed that he did not dispute that Petitioner fell on her right hand after being told to exit the rear of the school bus during a mandatory evacuation drill. He testified that he did not have reason to dispute Petitioner's supervisor's notation that her wrist and upper arm were throbbing down to the fingers. He testified that a fracture was a painful condition, especially during its acute phase. He testified that an acute TFCC tear could be painful. (RX1).

On cross examination, Dr. Williams agreed that if Petitioner's primary care physician noted on October 13, 2015 that she had pain in her right side and complained of pain on palpation, he would have no reason to dispute that. He testified that the right paracentral disc herniation with mild cord flattening and deformity in the cervical spine may not necessarily be a painful condition. He testified that a disc herniation is not necessarily a painful condition but can be. He testified that degenerative disc disease with right greater than left foraminal stenosis can be a painful condition and that it could be confirmed by MRI and would be objective. He testified that disc degeneration was a chronic condition that had occurred over a long period of time and was not an acute finding, but that a disc herniation could be. (RX1).

On cross examination, Dr. Williams agreed that a rotator cuff tear with retraction largely involving the supraspinatus tendon but also partial tearing of the subscapularis and infraspinatus tendons could be a painful condition as could a loose body within the subacromial and subdeltoid bursa. He testified that these would be objective findings able to be confirmed by an MRI. He testified that a tear of the lateral meniscus could be a painful condition. He testified that depending on the findings on an MRI, rotator cuff and meniscal tears could be read as chronic or acute. He testified that arm and hand pain can be sign of injury to the cervical spine. (RX1).

On cross examination, Dr. Williams agreed that Petitioner reported to him that she had improved about 75% since the fall at work. He agreed that he did not make any specific findings that any of her treatment did not help her or was unreasonable or unnecessary. He agreed that Petitioner fell out of a bus and caught herself on her hand in such a way that it caused a fracture. He testified that Petitioner's fall could have cause a temporary worsening of pain for her other conditions. (RX1).

On cross examination, Dr. Williams testified that his board certification included the American Board of Physical Medicine and Rehabilitation as well as well as certification from what used to be called the American Academy of Disability Evaluating Physicians. He testified that he has certifications for both the AMA Guides Fifth and Sixth editions, and that he was also a certified independent medical examiner from the American Board of Independent Medical Examiners. (RX1).

The medical records of Anderson Hospital were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records reflect that Petitioner underwent x-rays of the right shoulder on May 22, 2000, which were interpreted as revealing rotator cuff calcification at its insertion could account for symptoms of tendinitis. Petitioner was seen in the Emergency Department on June 5, 2000, at which time she complained of right ankle pain. Petitioner underwent x-rays of the right hip on December 20, 2001, which were interpreted as revealing punctate calcified density in the superior aspect of the acetabulum consistent with osteophyte or punctate chip fracture. Petitioner underwent x-rays of the right hip on April 1, 2002, which were interpreted as negative. Petitioner underwent x-rays of the right knee on April 8, 2003, which were interpreted as revealing mild osteoarthritic change. Petitioner underwent x-rays of the

right hip on January 16, 2004, which were interpreted as revealing no acute osseous abnormality of the right hip. Petitioner underwent an MRI of the right hip on June 5, 2004, which was interpreted as a normal MRI examination of the bilateral hips. (RX2).

The records of Anderson Hospital reflect that Petitioner was seen in the Emergency Department on February 6, 2005, at which time she reported numbness in the bilateral hands for the past two months. The assessment was that of neuropathy. Petitioner underwent x-rays of the cervical spine on that date, which were interpreted as revealing (1) no acute osseous abnormality of the cervical spine identified; (2) minimal anterolisthesis C2 on C3 most likely degenerative. Petitioner underwent an EMG on February 21, 2005, which was interpreted as revealing severe bilateral carpal tunnel syndrome, right more than left. An MRI of the cervical spine performed on March 4, 2005 was interpreted as revealing reversal of normal cervical lordosis with prominent disc protrusions at C3-4, C4-5 and C5-6 resulting in cord compression; no evidence of abnormal signal intensity within the cord itself is seen. Petitioner underwent x-rays of the lumbar spine on March 8, 2005, which were interpreted as revealing degenerative changes, no evidence of acute bony abnormality. (RX2).

The records of Anderson Hospital reflect that Petitioner was seen on November 3, 2006 in the Emergency Department, at which time it was noted that she complained of left lateral neck pain after a motor vehicle accident. Petitioner was seen in the Emergency Department on May 22, 2007 after a motor vehicle collision. It was noted that Petitioner sustained burns to both forearms as well as mild right neck and shoulder pain. Petitioner was assessed with a cervical strain and bilateral forearm contusions. A CT of the cervical spine performed on that date was interpreted as revealing (1) no acute osseous abnormality of the cervical spine identified; (2) status post fusion with discectomy at C3-C6. X-rays of the cervical spine also performed on that date were interpreted as revealing (1) status post anterior cervical discectomy and fusion with interbody bone graft from C3-C6, new since February 6, 2005; (2) no prevertebral soft tissue swelling or displaced fracture of the cervical spine. X-rays of the right forearm also performed on the same date were interpreted as revealing (1) no acute osseous abnormality of the right forearm; (2) soft tissue swelling of the right forearm. (RX2).

The records of Anderson Hospital reflect that Petitioner underwent an MRI of the lumbar spine on March 3, 2009, which was interpreted as revealing (1) moderate bilateral neural frontal stenosis L5/S1, with some narrowing of left lateral recess as well; (2) lower lumbar spondylosis, with left neural foramen L2/3, L3/4 and L4/5 more narrowed than right; (3) lower lumbar facet arthropathy. Petitioner underwent an MRI of the right knee on July 22, 2011, which was interpreted as revealing (1) severe chondrosis of lateral and patellofemoral compartments and moderate chondrosis of medial compartment; (2) complex tears of medial and lateral menisci; (3) chronic sprains of medial and fibular collateral ligaments; (4) large knee joint effusion. X-rays of the right knee also performed on that date were interpreted as revealing right knee osteoarthritis with the patellofemoral, lateral tibiofemoral compartments most affected. Petitioner was seen by Dr. Bicalho on September 12, 2011 for right knee pain. It was noted that it occurred occasionally, that there was no radiation, that the pain was aching and sharp and that there was no injury. It was noted that Petitioner's MRI was consistent with medial and lateral meniscus tears. It was noted that a right knee arthroscopy for meniscal tear was recommended. The Operative Report dated September 14, 2011 noted that Petitioner underwent (1) right knee arthroscopy; (2) partial medial meniscectomy; (3) partial lateral meniscectomy; (4) chondroplasty by Dr. Bicalho for pre-operative diagnoses of (1) right knee medial meniscus tear; (2) lateral meniscus tear and post-operative diagnoses of (1) right knee medial meniscus tear; (2) lateral meniscus tear; (3) tricompartmental degenerative arthrosis. (RX2).

The records of Anderson Hospital reflect that Petitioner underwent an MRI of the lumbar spine on March 19, 2012, which was interpreted as revealing (1) mild spondylosis; (2) mild to moderate facet arthropathy. Petitioner underwent an MRI of the lumbar spine on March 31, 2012, which was interpreted as revealing severe degenerative change of lower lumbar spine with worsening at L4-L5 where there is

severe central canal stenosis. Petitioner was seen on March 25, 2013 after a motor vehicle crash that morning, after which she complained of back pain. The primary diagnosis was noted to be that of acute back pain status post motor vehicle collision. X-rays of the lumbar spine performed on that date were interpreted as revealing unchanged severe lumbar spondylosis without evidence of acute fracture. Petitioner was seen on April 9, 2013 by Dr. Lin, at which time it was noted that she complained of low back pain, standing pain and walking pain, that she could not walk very far and that she could not stand for very long. It was noted that Petitioner stated that she had been having this problem for about 2 years, that she was walking in the preschool, tripped and fell, and that since then it seemed to be getting worse. It was noted that the impression was that of protrusion of the disk, degenerative disk at L4-L5 and L5-S1, and also L3-L4 causing spinal canal narrowing and spinal stenosis at L4-L5. It was noted that Petitioner should consider epidural block treatment, among others. Petitioner underwent an epidural block treatment and epidurogram on April 17, 2013. Petitioner underwent an additional epidural block treatment and epidurogram on both April 24, 2013 and May 1, 2013 as well. (RX2).

The medical records of Spine and Wellness Center, LLC were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that Petitioner completed her initial paper work on July 30, 2013, at which time she noted low back pain and right knee pain down to her foot. It was noted that Petitioner's pain was constant. The records reflect that Petitioner treated for the cervical, thoracic and lumbar spines throughout the timeframe of September 12, 2013 through February 23, 2015. (RX3).

The medical records of Chiro-Med were entered into evidence at the time of arbitration as Respondent's Exhibit 4. The records reflect that Petitioner completed a Registration Form on March 13, 2015, at which time she noted that her major complaints were that of right knee, tingling on the side of her legs, neck and back, that she had had the condition for six years and that she had had this or similar conditions in the past. Petitioner was seen on March 13, 2015, at which time it was noted that her chief complaints included left cervical, cervical and right cervical discomfort and left anterior knee pain. The assessment was noted to be that of sciatica; cervical spondylosis without myelopathy; L/S spondylosis without myelopathy; cervical subluxation; lumbar subluxation; segmental dysfunction lower extremity; spasm of muscle. The records reflect that Petitioner treated with Dr. Weber for the timeframe of March 13, 2015 through October 6, 2015. At the time of the March 30, 2015 visit, it was noted that Petitioner had a secondary complaint in her right anterior knee and right posterior knee region in addition to the prior noted complaints. The records reflect that Petitioner continued to report complaints regarding the right knee at various times throughout the remainder of her treatment with Dr. Weber. (RX4).

The medical records of Dr. James Simmering were entered into evidence at the time of arbitration as Respondent's Exhibit 5. The records reflect that Petitioner was seen on June 1, 2012, at which time her Chronic Problems were noted to include, among others, osteoarthrosis, generalized; pain in limb; and lumbago. It was noted that as to the lumbago diagnosis, Petitioner was instructed to continue physical therapy and exercises as directed and to follow-up immediately if her symptoms worsened or new symptoms developed. At the time of the March 27, 2013 visit, it was noted that Petitioner presented with an onset of back pain two days ago, that the pain was in her lower back and legs and that the pain radiated to the right calf and right thigh. It was noted that trauma occurred due to an MVA while in the street on March 25, 2013. It was noted that Petitioner got hit while in a car by a snow plow and that it aggravated her back pain and sciatic pain on the right side. Petitioner was instructed to continue physical therapy and exercises as directed and to follow up immediately if her symptoms worsened or new symptoms developed. At the time of the May 14, 2013 visit, it was noted that Petitioner reported back pain with an onset of six months ago. It was noted that the location of the pain was in the lower back and left flank, and that the pain radiated to the right calf, right foot, left thigh and right thigh. It was noted that Petitioner had seen Dr. Lin for pain management and had three epidural injections, was doing exercises and was

losing weight. Petitioner was instructed to continue physical therapy and exercises as directed and to follow up immediately if her symptoms worsened or new symptoms developed. (RX5).

The records of Dr. Simmering reflect that Petitioner was seen on September 10, 2013, at which time it was noted that her back pain was worsening and that the location was the left flank. Petitioner was ordered to undergo a CT of the abdomen/pelvis. At the time of the May 20, 2014 visit, it was noted that Petitioner was seen for back pain with an onset of two weeks ago. It was noted that the location of the pain was in the middle back. Petitioner was instructed to undergo a CT renal stone study. At the time of the February 6, 2015 visit, it was noted that Petitioner reported low back pain that radiated to the right calf, right foot and right thigh. It was noted that Petitioner was seeing Dr. Bicalho for her knee and that she was seeing a chiropractor. The assessment was noted to be that of spinal stenosis at L4-L5 level. Petitioner was referred to physical therapy, neurosurgery and pain management. (RX5).

The Contract in 03 WC 13068 was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The Contract reflects that Petitioner filed a claim for a date of accident of December 19, 2001 for right knee, hip and leg alleged injuries after having slipped while walking up stairs and falling onto her right knee. The claim was settled for 4% of the person-as-a-whole. (RX6).

CONCLUSIONS OF LAW

The parties stipulated at the time of arbitration Petitioner sustained an accident on October 7, 2015 that arose out of and in the course of her employment with Respondent. (AX1).

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds Petitioner has failed to prove that her current condition of ill-being in the right shoulder, right knee, right hip, back or neck is causally related to the accident of October 7, 2015, but that Petitioner has proved that her current condition of ill-being in the right little finger and right hand is causally related to the accident of October 7, 2015.

In so concluding, the Arbitrator notes that the initial post-accident medical records reference issues only with the right little finger and right wrist/hand. The medical records entered into evidence at the time of arbitration reflect that Petitioner's extensive medical history details pre-existing, unresolved injuries to each of the right shoulder, right knee, right hip, back and neck. (RX3; RX4; RX5). This significant pre-accident treatment to the same body parts, when considered with the histories as provided by Petitioner to Dr. Barnett, Dr. Weber and Dr. Mall -- all of which fail to record any alleged injuries to the right shoulder, right knee, right hip, back or neck -- significantly influence the Arbitrator's findings in this case as to the issue of causation. Furthermore, the Arbitrator notes that Petitioner did not author an injury report until approximately 19 days after her fall, and that none of the other reports authored at that time mentioned any injuries other than those to Petitioner's finger and wrist. (PX16). Having considered and reviewed the entirety of the medical testimony offered in the case, the Arbitrator finds the opinions of Dr. Williams to be more persuasive than those of either Dr. Mall or Dr. Weber, as it appeared that he had a more thorough and complete understanding of the specifics of Petitioner's significant pre-accident medical history.

As a result of the foregoing, the Arbitrator finds Petitioner has failed to prove that her current condition of ill-being in the right shoulder, right knee, right hip, back or neck is causally related to the accident of October 7, 2015, but that Petitioner has proved that her current condition of ill-being in the right little finger and right hand is causally related to the accident of October 7, 2015.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, in light of the Arbitrator's finding as to the issue of causation, the Arbitrator finds that Respondent shall pay all reasonable and necessary medical services for Petitioner's right little finger and right hand as contained in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that an AMA rating was offered by Respondent, which was that zero impairment for the middle phalanx fracture as well as the right wrist sprain. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that the record reveals that Petitioner was employed as a teacher's assistant both before and after her fall. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 62 years old on her date of accident. Given the advanced age of Petitioner and the fact that the medical records lack any reference to Petitioner having been placed under any restrictions, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following her work injury, Petitioner returned to her position as a teacher's assistant for Respondent. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that her right little finger has a little bit of motion, but not like the one on her left hand where she can touch her palm. She testified that she still has some pain, but that it was not severe like it was before. She testified that she is able to write and can do normal holding of things but that heavy lifting is a problem. She testified that her fractured finger is unable to be flattened out and that it stays bent. She testified that her right wrist is better but that she still has some pain. She testified that the range of motion in both of her wrists is not the same and that she feels some stiffness and does exercises to get it loose. She testified that she can lift more with her left wrist and that she tends to do less lifting with the right hand. At the time of the January 6, 2016 visit with Dr. Burton, Petitioner's more recent complaints involved resolving stiffness with the right small finger but the inability to fully extend and flex the small finger, that the swelling that was once present had resolved and that she sometimes had pain when she bumped the small finger. It was noted that Petitioner's biggest complaint was stiffness involving the small finger and that she stated that her stiffness was resolving with therapy. It was noted that Petitioner could work with no restrictions as it pertained to her right hand. (PX11). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely her continued complaints and limitations, were somewhat corroborated by her treating records at the conclusion of her treatment based on the medical records

submitted into evidence at the time of arbitration. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **7.5% loss of use of the right hand and 15% loss of use of the right little finger** as provided in Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brenda Phillips,

Petitioner,

vs.

NO: 14WC014896
14WC014897
15WC030576

Human Service Center,

Respondent.

18IWCC0174

DECISION AND OPINION ON REVIEW

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

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

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: MAR 22 2018
SJM/sj
o-3/8/18
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PHILLIPS, BRENDA
Employee/Petitioner

Case# **14WC014896**

14WC014897
15WC030576

HUMAN SERVICE CENTER
Employer/Respondent

18IWCC0174

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:

1824 STRONG LAW OFFICES
TODD A STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

5354 STEPHEN P KELLY LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

18IWCC0174

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

BRENDA PHILLIPS,
Employee/Petitioner

v.

HUMAN SERVICES CENTER,
Employer/Respondent

Case # 14 WC 14896

Consolidated cases: 14 WC 14897
15 WC 30576

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **5/11/17**. 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 **10/7/13, 11/18/13 and 12/17/13**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

On 10/7/13 and 12/17/13, Petitioner *did* sustain an accident that arose out of and in the course of employment.

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

Petitioner's current condition of ill-being for her left shoulder *is* causally related to the accidents she had on 10/7/13 and 12/17/13 through 1/31/14, and Petitioner's current condition of ill-being for her low back *is* causally related to the accidents she had on 10/7/13 and 12/17/13 through 5/2/14.

In the year preceding the injury, Petitioner earned **$19,647.16**; the average weekly wage was **$377.83**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **3** dependent children.

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

Respondent ***has or will*** pay all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit for any nonoccupational indemnity disability benefits paid to respondent.

Respondent is entitled to a credit under Section 8(j) of the Act for any nonoccupational indemnity disability benefits.

ORDER

Petitioner's claim for temporary total disability benefits is denied.

Respondent shall pay Petitioner permanent partial disability benefits of $330.00/week for 20 weeks, because the injuries sustained caused the 4% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services for petitioner's left shoulder from 10/7/13 through 1/31/14, and for petitioner's low back from 10/7/13 through 5/2/14, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Maureen H. Pulia

Signature of Arbitrator

5/30/17
Date

ICArbDec p. 2

JUN 12 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 55 year old recovery support tech (RST), sustained an injury that arose out of and in the course of her employment by respondent on 10/7/13 and 12/17/13. Petitioner alleges she also sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/18/13. Petitioner is a diabetic that struggles to keep her blood sugars in order. Petitioner is not claiming any treatment related to her diabetes is related to these claims.

Petitioner was an RST for respondent, and on the dates of injury worked with detox clients at Residents in Transitional Services (RITS). The inmates petitioner dealt with were in a halfway house after having left federal prison and were transitioning back into society. Petitioner's duties included dealing with the daily needs of the inmates, tracking them when they would leave the halfway house to find work, serving them food, and reporting on them to the case managers. There were 18-27 inmates in the halfway house at any given time.

Prior to the first injury on 10/7/13 petitioner reported issues with her low back and left shoulder. On 3/7/13 petitioner presented to OSF Saint Francis Medical Center for follow-up of her diabetes. While there she reported that for the last week or so she had been having some back pain that went down her left side into her abdomen and groin. She reported that she was seen in the emergency room and was told she had a piriformis syndrome. She reported that she was given muscle relaxants and Norco, but the pain was still there. A kidney stone was suspected.

Petitioner was assessed with sharp stabbing pain in the low back and right side of the back on 1/31/07; with sciatica on 2/20/07 and restricted to lifting in excess of 50 pounds; and with a strain and spasms of the left trapezius on 2/29/12. Petitioner was also in a motor vehicle accident in 2008 and sustained an injury to her low back. She had an MRI. She testified that she had sciatica. Petitioner filed a lawsuit for this accident and received a settlement. In the deposition for that accident she testified that she had problems with her low back as a result of the motor vehicle accident.

Also prior to the injury on 10/7/13, petitioner filed various claims for short term disability while working for the respondent. She filed one on 1/22/07 for low back pain and left shoulder pain after sustaining an injury while moving a milk crate at work. Petitioner testified that she underwent physical therapy and injections for her left shoulder as a result of this injury. She also testified that she was on light duty for awhile following this injury. On 2/28/12 petitioner filed for short term disability benefits with respondent due to left shoulder complaints. At that time, petitioner was treating with Dr. Smith at OSF for her left shoulder. This treatment included occupational therapy. Also in February 2012 petitioner filed for short term disability for her low back.

On 10/7/13 (14 WC 148797), petitioner was stationed at the RST station and a female inmate was having a seizure at a picnic table and she tried to catch the inmate and lay her on the ground. As the inmate was on the ground having her seizure, petitioner tried to protect her head so that it would not hit the concrete. As petitioner was attempting to restrain the inmate during her seizure she injured her left shoulder and low back.

Petitioner completed an Incident/Accident Report and dated it 10/7/13. She also signed it. She gave a consistent history the accident. She alleged injuries to her low back and left shoulder.

Petitioner presented to the emergency room for treatment on 10/7/13 around 11:30 pm with shoulder pain. She provided a consistent history of the injury. She stated that she did not notice any pain immediately afterwards, but had increasingly worsened left shoulder and low back pain. Straight leg raise was positive on the left. X-rays of the left shoulder showed mild arthritic changes of the left acromioclavicular joint. X-rays of the lumbar spine showed no interval changes since previous plain films of the lumbar spine on 9/8/08; mild anterior physiologic wedging T11 vertebral body unchanged from 9/8/08; facet arthropathy at the L4-L5 and L5-S1 levels; and degenerative narrowing of the hips bilaterally.

On 10/10/13 petitioner presented to OSF St. Francis Medical Center with ongoing complaints in the left arm and tenderness in the low back. Global decrease of strength in the left shoulder was noted. Petitioner indicated that the pain was in the lateral aspect of the left deltoid. She stated that she has had low back pain for years. Tenderness was noted in the lumbar spine at L4-L5 and straight leg raise was negative. Petitioner was assessed with a low back strain, and left shoulder strain. Petitioner was given Motrin. Petitioner was given restriction of no lifting over 10 pounds for 2 weeks.

On 10/31/13 petitioner presented to OSF HealthCare System complaining of back pain, as well as bilateral shoulder pain. She reported that soon after the accident she stated having some shoulder and back pain. It was noted that petitioner had some chronic issues with this but reported that since then her pain had been exacerbated. She rated her back pain at a 6-8/10. She reported bilateral shoulder pain at a 6/10. She reported that the right and left shoulder pain was burning and radiating to the biceps. Petitioner denied any popping or pulling. She reported tightness and stiffness throughout her left shoulder, neck and upper back. She denied any numbness or tingling. She gave a history of a left shoulder injury 1-2 years ago. Petitioner was assessed with bilateral shoulder pain that was aggravated by the injury. It was noted that petitioner told the healthcare provider that she had a known rotator cuff tear on the left. Petitioner was assessed with a possible exacerbation of that rotator cuff tear. A possible rotator cuff tear on the right was also assessed, as well as acute low back pain with a negative straight leg raise.

On 11/5/13 petitioner was seen at Illinois Neurological Institute. The referring physician was identified as Dr. Linn. Petitioner reported symptoms from the left side of her neck to the posterior right deltoid, the right deltoid, the low back and posterior left thigh. Petitioner related these symptoms to her work injury on 10/7/13. Petitioner underwent additional physical therapy sessions on 11/13/13, 11/19/13, 11/27/13, 12/3/13, 12/4/13, and 12/10/13. On 12/10/13 petitioner reported that she had hardly any pain in her left shoulder, and rated her low back pain at 4/10.

On 11/18/13 (15 WC 30576), petitioner alleges she sustained another injury to her low back while trying to keep an inmate from falling off a couch while having a seizure. Petitioner testified that she reported the injury to the building manager, Jan Cullinane, her main supervisor.

Petitioner offered into evidence an Incident/Accident Report for an injury on 11/18/13 at 8:25 am. She reported an injury consistent with her testimony at trial. However, this report is not signed by petitioner, or dated. Additionally, petitioner did not file her Application for Adjustment of Claim for this case until 9/22/15. On the Application for Adjustment of Claim she alleged that she sustained injuries to her person as a whole after being attacked by an inmate on 11/18/13.

Petitioner testified that following the incident she had a lot of pain in her low back. On 12/5/13 petitioner returned to OSF St. Francis Medical Center for follow-up of her bilateral shoulder pain. Petitioner reported that the physical therapy helped her shoulders and she felt improved. Physical therapy was continued.

Petitioner alleges that on or about 12/17/13 (14 WC 14896), she was watching an inmate on the camera. As she was headed towards the bathroom the inmate walked directly into her knocking her off her path. An Incident Report was completed on 12/18/13. This report is consistent with petitioner's accident history. This reported was handwritten, and signed and dated by petitioner.

On 12/18/13 petitioner attended another session of physical therapy. Petitioner reported that the night before an inmate was being mean and knocker her off her path while she was walking. She rated her pain at a 4/10. On 1/22/14 petitioner rated her back pain at 6/10. There was no specific mention of any left shoulder pain. On 1/31/14 she rated her low back pain at 3/10.

On 2/6/14 petitioner presented to Heartland Community Health Care. Petitioner reported pain in the left buttock radiating to the left foot following an injury 2 months ago. Straight leg raise was positive at 30 degrees bilaterally, and tenderness was noted in the left sciatic notch in the buttock. A neurological examination was normal. Additional physical therapy was prescribed. Neurontin was also prescribed.

Petitioner did not treat from 2/7/14 through 5/3/14.

On 4/2/14 Dr. Michael Triester at Physicians Review Network, Inc. performed a retrospective review of medical treatment and pre-certification for additional physical therapy ordered on 2/6/14. Following his record review Dr. Treister felt that petitioner had a long standing pathology in the left shoulder and low back. He further noted that petitioner had a diagnosis of sciatica and radiculopathy long before the work injury. Dr. Triester was of the opinion that eight physical therapy sessions following the injury on 10/7/13 would have been reasonable and necessary. He opined that no further physical therapy visits would be reasonable and necessary.

Petitioner testified that prior to 4/25/14 she had not yet been referred to an orthopedic doctor for her left shoulder or low back. She testified that she did have a prior relationship with Dr. Hoffman. However, no medical records before 5/7/14 were offered into evidence. Petitioner then testified that the first time she saw Dr. Hoffman was on 5/7/14.

On 5/1/14 petitioner filed her Application for Adjustment of Claim with respect to the accident on 12/17/13. She alleged that she was struck by an inmate and injured her back, both shoulders and arms. This Application was signed by petitioner, but not dated.

On 5/1/14 petitioner filed her Application for Adjustment of Claim with respect to the accident on 10/7/13. She alleged that she was injured while assisting an inmate who was having a seizure. She alleged injuries to her back, both shoulders and arms. This Application was signed by petitioner, but not dated.

On 5/3/14 petitioner presented to the emergency room at St. Francis Medical Center with progressive left leg pain over the past several years and acute back pain. There was a question as to whether or not her weakness in her left leg was true weakness versus effort. It was difficult to discern. She reported that her back pain started earlier that day and had been getting worse. She rated it at a 10/10. She gave a history of an accident in 2003 that caused back pain in the same location that resolved after a massage and recurred after an injury in October of 2013 and has been constant since, and worse that day. She was examined and assessed with acute back pain with left sciatica. Petitioner underwent an MRI of the lumbar spine. The impression was no evidence of central canal stenosis or neural foraminal encroachment, and multilevel disc and facet degeneration.

On 5/7/14 petitioner presented to Dr. Daniel Hoffman. She gave a history of trying to help an inmate during a seizure and twisted her low back and left shoulder. She alleged that she also reinjured her left shoulder in November when an inmate ran into her left shoulder. He assessed a shoulder strain and multi disc disease of the lumbar spine and referred petitioner for therapy, and to Dr. Kube for her back. He also ordered an MRI of the left shoulder.

On 5/15/14 petitioner underwent an MRI of the left shoulder. The impression was supraspinatus tendinosis and probable partial-thickness tear; tendinosis of the subscapularis tendon; and possible labral tear.

On 5/21/14 petitioner presented to Dr. Rhode for consultation of left shoulder pain related to work accident on 9/24/13. She reported that an inmate was having a seizure and she had to stabilize the inmate's upper body during the seizure. Petitioner reported a prior left side injury in 2003 that she recovered from fine. She also reported an injury to the same shoulder in 2004 for which she had no treatment and also recovered. She denied any left shoulder complaints from 2004 until the accident on 10/7/13. She complained of lateral shoulder pain and weakness to forward reach and overhead lift. Petitioner was examined and assessed with a partial thickness supraspinatus tear. Dr. Rhode performed an injection. Dr. Rhode took petitioner off work.

On 5/22/14 petitioner presented to Dr. Kube for her low back pain going on for several months. She reported that it worsened on 5/2/14. She reported that she injured her back before in 2003. She reported an injury while assisting an inmate who was having a seizure in September or October of 2013. She reported that in 2003 she fell on her buttock, but that resolved. She also reported another back injury at work with some type of 5 pound milk machine in 2004, that had resolved. Following an examination Dr. Kube assessed pain in her mid back radiating out toward the left side. He ordered an EMG/NCV. Petitioner was taken off work.

On 6/2/14 petitioner underwent an EMG/NCV of the lower extremities. Petitioner gave a history of sustaining an injury on 10/7/13 and stated that she tried to keep on working despite her discomfort. She also reported that one month ago on 5/2/14 she had an exacerbation of severe back pain and has not been able to work. She complained of pain shooting down both legs, worse on the left, since she had a lifting incident with a milk cart in 2004. The results of the tests were normal.

On 6/17/14 petitioner returned to Dr. Kube. Dr. Kube noted that the EMG/NCV was negative and the MRI only showed very minimal degenerative changes. He assessed a possible sacroiliac joint disorder. He recommended injections.

On 6/18/14 petitioner returned to Dr. Rhode and reported temporary relief after the injection. She informed Dr. Rhode that she wished to proceed with an arthroscopic left shoulder subacromial decompression and possible rotator cuff repair. Dr. Rhode requested authorization. Petitioner continued to follow-up with Dr. Rhode and remained off duty while awaiting authorization. He instructed petitioner to follow-up 7-10 days postoperatively. Despite this directive petitioner continued to follow-up with Dr. Rhode on 7/16/14, 7/30/14, 8/27/14, 9/10/14, 9/24/14, 10/8/14, 11/22/14. Petitioner's condition was unchanged during each visit.

On 6/30/14 petitioner underwent bilateral sacroiliac joint injections. This procedure was performed by Dr. Kube.

On 7/7/14 petitioner presented to the emergency room at St. Francis Medical Center with complaints of left leg pain. She reported an onset of left leg pain since 2000, with worsening pain in October of 2013, and chronic pain since.

On 7/16/14 Physical Therapist Ausili noted that petitioner had not been seen in therapy since 1/22/14 and discharged her from care.

On 8/4/14 Dr. Kube had petitioner undergo a pelvis series and a sacroiliac joint series of x-rays. They showed no major degenerative changes in her sacroiliac joints. Petitioner reported that the injections provided almost complete relief on the right side. He continued petitioner off work.

On 8/20/14 petitioner underwent a left sacroiliac joint injection performed by Dr. Kube. On 8/26/14 Dr. Kube released petitioner to light duty for 2 weeks and then full duty.

On 9/2/14 Petitioner reported that the left side injection really knocked her pain down. She still reported quite a bit of pain by the end of the day and at night associated with the sacroiliac joint. He recommended that she work half days for two weeks, and then return to full duty. She was prescribed therapy.

On 9/10/14 petitioner reported to her therapist that she had been in a motor vehicle accident the day before and was having increased symptoms. She reported that she would be going to the emergency room after her therapy.

On 9/11/14 Terry Lawson, Vice President, Human Resources, Human Service Center, drafted a letter to petitioner. The letter informed petitioner that she had been off work since 5/4/14, and that effective 9/11/14 she had been approved for long term disability benefits. Petitioner was also informed that her FMLA was exhausted on 7/27/14. Petitioner was informed that since respondent was unsure when she would be able to return to work based on her report and the report of her doctor, that her position was going to be filled. Petitioner was told she would be considered for another position in the organization when she was able to return to work.

On 9/14/14 petitioner presented to Dr. Rhode with complaints of low back and neck pain following a motor vehicle accident on 9/9/14. She reported that she was a passenger in a car that was rear-ended by a car traveling at a moderate speed. She noted that she was thrust forward and experienced a sudden onset of bandlike low back pain and cervical pain. She was assessed with a cervical and lumbar strain and prescribed physical therapy for this injury that began on 9/29/14. She reported lumbar radiculopathy.

On 10/15/14 petitioner last followed-up with Dr. Hoffman. She continued to complain of pain in her left shoulder and LS spine. He assessed multiple discs, LS strain, shoulder strain, and tear. He released her to light duty with no lifting.

On 11/10/14 petitioner last presented to physical therapy for her low back. She reported that she was much better. The therapist reported that petitioner had made good progress throughout her course of therapy. It was noted that her strength was improved.

On 12/5/14 petitioner last followed-up with Dr. Kube. He noted that she was doing quite well, especially given the fact that she had been released to full duty. Dr. Kube was of the opinion that petitioner had reached maximum medical improvement. He discharged her from his care

On 1/27/15 petitioner underwent a left shoulder subacromial decompression/debridement, chodroplasty glenoid and arthroscopic rotator cuff repair performed by Dr. Rhode. His diagnosis was left shoulder impingement/bursitis, glenoid chondromalcia-Grade 4 and 1.5 cm by 1 cm U-shaped supraspinatus rotator cuff repair. Petitioner followed up post-operatively with Dr. Rhode. This treatment included a physical therapy from 2/26/15 to 7/28/15.

Petitioner followed-up with Dr. Rhode or his physician's assistant Lori Welke on 2/11/15, 2/25/15, 3/25/15, 4/22/15, 5/4/15, 5/20/15, 6/17/15, 7/15/15. On 4/22/15 petitioner was released to modified light duty work. On 5/20/15 Dr. Rhode performed an injection into the left shoulder. He noted a moderate strength deficit with residual lateral shoulder pain. On 6/17/15 petitioner reported that the injection provided moderate relief. Her complaints remained the same. Dr. Rhode ordered that petitioner finish physical therapy and undergo an FCE. He continued her light duty restrictions with no overhead lifting greater than 5/10.

On 7/25/15 and 7/28/15 petitioner underwent a Functional Capacity Evaluation (FCE) at Work Well Systems, Inc., at Orland Park Orthopedics. Although a formal job description was not provided, the therapist found petitioner's capabilities did not match the job duties as described by petitioner.

On 7/27/15 at her last physical therapy visit petitioner rated her pain at 3-4/10. She felt that her shoulder had not fully healed. She reported that flexion and abduction to the left shoulder was painful. She reported that the pain in her left shoulder comes and goes.

On 7/29/15 Dr. Rhode released petitioner to light duty work maximum lift/carry less than 20 pounds, and frequent at 10 pounds. He restricted above shoulder maximum to 10 pounds, and 5 pounds frequently. Dr. Rhode was of the opinion that these restrictions were permanent.

On 8/5/15 Dr. Rhode performed The Nature and Extent of Disability Report and an Impairment Rating based on the AMA Guides 6th Edition. His final impairment was 6% of the left upper extremity and 4% of the whole person.

On 8/26/15 the evidence deposition of Dr. Rhode was taken on behalf of petitioner. Dr. Rhode opined that petitioner's mechanism of injury as she described, is causally related to her condition in the left shoulder that he diagnosed and treated. He further opined all the treatment he provided for her left shoulder was reasonable and necessary.

On cross examination Dr. Rhode testified that petitioner told him she injured herself on 9/24/13, not 10/7/13. He also testified that she never reported an injury to her left shoulder occurring in December of 2013. Dr. Rhode testified that he did not review any records other than those from St. Francis Medical Center. He was of the opinion that he could not determine the age of tear he saw in petitioner' left shoulder, almost a year after the alleged injury on 9/24/13. He testified that petitioner also gave a history of an inmate bumping her left shoulder on 1/7/15. Dr. Rhode admitted that he had not reviewed any medical records of petitioner from before September of 2013. Dr. Rhode opined that the petitioner's described mechanism of injury would not cause some condylar lamination to the glenoid. He was of the opinion that it might be caused by a shoulder dislocation. He was of the opinion that if petitioner did not recover as she claimed after the 2003 accident and had continued complaints that could explain the findings he saw in surgery. He was of the opinion that if she had a compressive load to her shoulder when she fell in 2003 that would be a competent explanation for a delaminating condylar injury. Dr. Rhode considered petitioner to be an outlier as it relates to symptom magnification. He found her strength loss was greater than he would expect for the small tear she had and the fact that it was shown to be intact after the surgery. Dr. Rhode was of the opinion that petitioner should be working.

On 9/22/15 petitioner filed her Application for Adjustment of Claim with respect to the alleged accident on 11/18/13. She alleged that she was attacked by an inmate and injured her person as a whole. This Application was signed by petitioner, but not dated.

On 9/29/15 petitioner underwent a Section 12 examination performed by Dr. Mitchell Rotman. Petitioner complained of a lot of left shoulder pain. Petitioner gave three separate injuries to her left shoulder, with the 1st being in 2008 when she lifted a milk crate, and the other 2 on 10/7/13 and 12/17/13. Following an examination and record review, Dr. Rotman assessed magnification of symptoms. He was of the opinion petitioner had some obvious give-way weakness; had several non-physiologic responses; and she did not give adequate effort on several of the tests. As a result, Dr. Rotman was concerned her subjective complaints were not reliable. Dr.

Rotman noted that the original MRI of the left shoulder showed no evidence of arthritis of the glenohumeral joint, and did not even show a full thickness rotator cuff tear. He was of the opinion that petitioner has arthritic changes involving the glenohumeral joint which had obviously progressed since her original treatment. He was also of the opinion that none of her reported three left shoulder injuries would have caused arthritis of the shoulder, loss of the cartilage on the glenoid surface, or involved any overhead activities or maneuvers about the shoulder that would have caused a rotator cuff tear. He opined that petitioner's left shoulder condition was degenerative and not related to an injury, and that her left rotator cuff had findings consistent with age-related changes. He opined that petitioner's three left shoulder incidents triggered some discomfort from a preexisting diseased shoulder. He opined that the mechanism of none of these injuries caused the degenerative changes noted in her left shoulder that were treated by Dr. Rhode.

Dr. Rotman opined that petitioner's current complaints are most likely related to arthritis. He further opined that the rotator cuff lesion was small and easily repaired and did not appear to be a source of her current discomfort. Dr. Rotman opined that over the next several years petitioner's shoulder arthritis would continue to progress and she may in fact need a shoulder replacement, not related to any of the left shoulder injuries she reported. Dr. Rotman noted that the restrictions determined by the FCE differed from those of Dr. Rhode. Dr. Rotman opined that petitioner could actually do much more considering the fact that her arthritis is only minimal and the shoulder is a non-weight bearing joint. Dr. Rotman opined that petitioner had objective evidence of left shoulder arthritis, and as a result she would have some disability and impairment, but none of this is related to the accident on 10/7/13 or any of the other injuries she mentioned.

On 1/27/16 Dr. Rhode issued permanent restrictions for petitioner with respect to her left shoulder. These restrictions were a reiteration of those he placed on petitioner on 7/29/15. Dr. Rhode released petitioner from his care. He believed she had plateaued. Petitioner testified that she tried to return to work, but was told her job had been filled and she had been terminated. Petitioner did not look for any other jobs.

Petitioner offered into evidence an Incident/Accident Report for the alleged injury on 11/18/13 at 8:25 pm. The report was not signed or dated. The report indicated that petitioner was again attending to a female inmate having a seizure on a couch. As the inmate was coming out of her seizure she started to go back on and petitioner held her so that she would not fall off the couch. It was noted that this resulted in a reinjury to petitioner's low back. This report was typed.

Petitioner testified that she still has some pain in her left shoulder and ices it. She reported difficulty sleeping as a result of this pain. She testified that she cannot hold things in her left arm because they drop. She stated that her husband does the heavy lifting, and her grandkids take the laundry upstairs for her. Her grandkids

are from age 6 to 14. Petitioner testified that before the injuries she was able to work and do all her chores at home.

Petitioner is still taking hydrocodone. She admitted she was using hydrocodone before the injuries.

Petitioner testified that she may have received long term disability benefits for the periods she is claiming TTD. She also testified that she received short and long term disability benefits while she was off work. Petitioner is currently on SSDI and began receiving benefits as of May of 2015. She testified that she was told that she had to apply for SSDI when she was on short and long term disability benefits. Petitioner was never paid any TTD.

Petitioner testified that the incident where the inmate passed by her and struck her left shoulder was in December of 2013, not in September of 2013, which she reported to Dr. Rhode. She denied any work accident in September of 2013.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

The parties stipulate that the petitioner sustained an accidental injury that arose out of and in the course of her employment by respondent on 10/7/13 and 12/17/13. Petitioner alleges that she also sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/18/13. Respondent disputes this claim.

Petitioner testified at trial that she sustained an injury to her low back on 11/18/13 while trying to keep an inmate from falling off a couch while having a seizure. Petitioner did not seek any treatment that day and when she next presented for treatment for her accident on 10/7/13 she did not give a history of this injury to her health care providers.

When petitioner injured herself on 10/7/13 and 12/18/13 she completed an Incident/Accident Report for those injuries that were signed and dated by her. Although petitioner offered into evidence an Incident/Accident Report for alleged injury on 11/18/13, the arbitrator finds it significant that this report is not dated or signed by anyone. Petitioner also indicated on the Request for Hearing that she reported the injury on 11/18/13 to Jan Celleni, Jane Sherman, Terry King and Ann Mudd Husten. However, petitioner did not call any of these witnesses to corroborate her testimony.

Additionally, the arbitrator finds it significant that petitioner did not file her Application for Adjustment of Claim for this alleged injury until nearly two years later on 9/22/15. The arbitrator also finds it significant that on her Application for Adjustment of Claim she alleged that she was attached by an inmate and injured her

person as a whole. The arbitrator finds this accident history inconsistent with the testimony that petitioner provided at trial and on her alleged Incident/Accident Report, where she claimed that she was injured holding an inmate that was having a seizure.

Based on the above, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an injury to her low back that arose out of and in the course of her employment by respondent on 11/18/13. The arbitrator bases this opinion on the fact that petitioner did not have a signed and dated report for this alleged incident like she had for the incidents on 10/7/13 and 12/17/13; that she presented no witnesses to corroborate her history of her alleged injury; that she did not give a history of this alleged accident to any of her healthcare providers contemporaneous with the injury; and the fact that she did not file her Application of Adjustment of Claim with respect to this alleged injury until 9/22/15, and on it identified an entirely different explanation for how the accident occurred.

E. WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT?

Timely notice is only an issue with respect to the alleged accident on 11/18/13 (15 WC 30576). Having found petitioner failed to prove by a preponderance of the credible evidence that she sustained an injury to her low back that arose out of and in the course of her employment by respondent on 11/18/13, the arbitrator finds this issue moot.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

The issue of causal connection is in dispute for the two remaining claims, namely the accident on 10/7/13 and the accident on 12/17/13. Petitioner is alleging injuries to her back, and both shoulders as a result of the injuries.

Based on the petitioner's own Incident Reports she completed following the accidents on 10/7/13 and 12/17/13, as well as the medical records most contemporaneous to the injuries, the arbitrator finds the petitioner made no reference to any right shoulder injuries contemporaneous to the injury, and did not claim the right shoulder as an injured body part on her Incident/Accident Report dated 10/7/13. Therefore, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that any alleged right shoulder injury is related to the accidents on either 10/7/13 or 12/17/13.

Next the arbitrator will look at the causal connection between the petitioner's low back and left shoulder injuries. It is unrebutted that petitioner had preexisting issues with her left shoulder and low back prior to the injuries on 10/7/13 and 12/17/13. A review of petitioner's medical records prior to 10/7/13 show that in 2007, 2008, 2012, and as recently as 3/17/13 petitioner had complaints and treatment for her low back. In 2007

petitioner had stabbing pains in her low back radiating down her left leg and was assessed with sciatica, and left shoulder complaints after trying to lift a milk crate. She had injections into her left shoulder at that time. She was restricted to no lifting in excess of 50 pounds, and collected short term disability benefits. In 2008 she was in a motor vehicle accident and injured her low back. She filed a lawsuit and received a settlement. In 2012 she was assessed with a strain and spasms of the left trapezius and again went off on short term disability. For this injury she underwent a course of occupational therapy. At that same time petitioner was also on short term disability for her low back. As recently as 3/7/13, just 7 months prior to the accident on 10/7/13 petitioner was again treated for low back pain radiating to her abdomen and groin.

Based on petitioner's prior medical records, the arbitrator finds the petitioner was less than truthful when she stated that she had not had any treatment for her low back or left shoulder since 2003 and 2004, respectively.

Following the accident on 10/7/13 petitioner was treated at the emergency room for a low back strain and left shoulder strain. X-rays of the low back were unchanged from 2008. On 10/31/13 petitioner was assessed with shoulder pain aggravated by the injury. Petitioner told her provider that she had a known rotator cuff tear on the left. Based on that history, petitioner was assessed with a possible exacerbation of that rotator cuff tear. She was also assessed with acute low back pain with a negative straight leg raise. Petitioner underwent some physical therapy and on 12/5/13 reported that the it helped her shoulders and she was improved.

Petitioner then sustained her accident of 12/17/13. She continued in physical therapy and by 1/31/14 she was reporting no shoulder pain and low back pain at a 3/10.

Petitioner presented to Heartland Community Health Care on 2/6/14 and reported low back pain radiating to her left leg. Her straight leg raise was positive, but her neurological exam was normal. Petitioner had no complaints with respect to her left shoulder. Additional physical therapy was requested. However, Dr. Treister felt that petitioner had a long standing pathology in the left shoulder and low back, with sciatica and radiculopathy, long before the injury on 10/7/13. He was of the opinion that 8 therapy sessions following the injury on 10/7/13 would have been reasonable and necessary. Respondent did not authorize any further therapy.

Petitioner did not treat again until after she filed her Applications for Adjustment of Claims on 5/1/14.

After having hired an attorney petitioner started seeing a new primary care physician Dr. Hoffman, who referred her to Dr. Rhode for her left shoulder and Dr. Kube for her low back.

An MRI of the left shoulder performed 5/15/14 showed supraspinatus tendinosis and probable partial-thickness tear; tendinosis of the subscapularis tendon; and possible labral tear. The arbitrator finds these

findings consistent with petitioner's history to OSF HealthCare System on 10/31/13 that she had already had a known rotator cuff tear on the left.

Petitioner then began treating with Dr. Rhode for her left shoulder on 5/21/14. The arbitrator finds the history petitioner provided regarding her injury and prior treatment for her left shoulder was not consistent with the credible record. The petitioner told Dr. Rhode that she injured her left shoulder on 9/24/13, but petitioner has filed no accident for that date. She also reported an injury in 2003 and 2004, after which she claims she had no further treatment. Again, this history is not consistent with the credible medical records that show she had problems with her left shoulder in 2007 and 2012. For these injuries petitioner had injections and occupational therapy. Dr. Rhode assessed a partial thickness supraspinatus tear, but seems to have been unaware of petitioner's rotator cuff tear before the injury on 10/7/13.

Based on this inaccurate history of petitioner's preexisting left shoulder issues prior to 10/7/13, the arbitrator gives little weight to Dr. Rhode's opinion that the petitioner's mechanism of injury as she described, is causally related to her condition in the left shoulder that he diagnosed and treated. The arbitrator also finds it significant that Dr. Rhode was unaware of an injury on 10/7/13 or 12/17/13; that he could not determine the age of the tear in petitioner's left shoulder a year and a half after the alleged injury; that he had not reviewed any medical records prior to 9/1/13; that he opined that petitioner's described mechanism of injury would not cause some condylar lamination to the glenoid, but that the injury in 2003 could have; that from 1/22/14 through 5/7/14 petitioner had no complaints regarding her left shoulder; and that Dr. Rhode considered her to be an outlier as it relates to symptom magnification, and found her strength loss was greater than he would expect for the small tear she had, and the fact that it was shown to be intact after the surgery.

Dr. Rotman also examined petitioner for her left shoulder and assessed symptom magnification. He was also of the opinion that her subjective complaints were not reliable. Dr. Rotman was also of the opinion that the MRI of the left shoulder did not show a full thickness rotator cuff tear. He was of the opinion that petitioner had arthritic changes involving the glenohumeal joint which had progressed since her original treatment. He opined that none of the three injuries she reported would have caused arthritis of the shoulder, loss of cartilage on the glenoid surface, or involved any overhead activities or maneuvers about the shoulder that would have caused a rotator cuff tear. Dr. Rotman opined that petitioner's left shoulder condition was degenerative and not related to an injury, and that her left rotator cuff had findings consistent with age-related changes. He was of the opinion that the injuries merely caused petitioner some discomfort in her left shoulder on top of her preexisting degenerative condition. Dr. Rotman was not aware that petitioner had reported to OSF Healthcare System on

10/31/13 that she had a known rotator cuff tear on the left already. He was also of the opinion that her rotator cuff lesion was small and easily repaired and did not seem to be the source of her current discomfort.

Based on the above, as well as the credible evidence, with respect to petitioner's left shoulder, the arbitrator finds the petitioner sustained a strain of her left shoulder as a result of the injuries she sustained on 10/7/13 and 12/17/13 that had resolved by 1/31/14. The arbitrator bases this opinion on the fact that as of 1/22/14 petitioner reported no further complaints with respect to her left shoulder to her therapist, and made no further complaints regarding her left shoulder until she presented to Dr. Hoffman on 5/7/14, and was diagnosed with a left shoulder strain. The arbitrator adopts the findings of Dr. Rotman over those of Dr. Rhode, based primarily on the fact that petitioner was not honest with Dr. Rhode with respect to her prior left shoulder condition, and the fact that she had a known rotator cuff tear prior to the injury on 10/7/13. The arbitrator's finding is also based on Dr. Rotman's opinion that the mechanism of injury presented by petitioner could not have caused a rotator cuff tear. Lastly, the arbitrator found it significant that Dr. Rhode never reviewed any medical records prior to 9/1/13.

With respect to petitioner's low back complaints, petitioner also did not have any treatment for her low back between 2/7/14 and 5/3/14. On 5/3/14 petitioner presented to the emergency room and complained of progressive left leg pain over the past several years, and acute back pain. She stated that her acute back pain started earlier that day. She rated it at a 10/10. She gave a history of a similar injury in 2003, that recurred in October of 2013. The arbitrator finds this history is inconsistent with the credible medical record, which shows treatment for her low back and left leg as recent as 7 months prior to the injury on 10/7/13. She was again assessed with low back pain and sciatica, which she has had problems with since as far back as January of 2007. An MRI of the low back showed degenerative changes.

Dr. Hoffman referred petitioner to Dr. Kube and petitioner began treating with him on 5/22/14. She reported low back pain for several months that worsened on 5/2/14. She reported that on 5/2/14 she had a severe exacerbation of her low back pain and since then had not been able to work. She complained of pain shooting down both legs, left worse than right, since an injury in 2004. The EMG/NCV of her lower extremities was normal. Petitioner continued to treat with Dr. Kube for her low back through 8/4/14.

Then on 9/10/14 petitioner reported to her therapist an intervening accident. She stated that she had been in a motor vehicle accident the day before and was having increased symptoms. By 12/5/14 petitioner was doing quite well and Dr. Kube had released her to full duty work. He was of the opinion that she had reached maximum medical improvement and released her from his care.

Based on the above, as well as the credible evidence, with respect to petitioner's low back, the arbitrator finds the petitioner sustained a low back strain as a result of the injuries she sustained on 10/7/13 and 12/17/13. After 2/6/14, petitioner did not treat until she presented to the emergency room on 5/3/14 and reported a severe exacerbation of her low back pain earlier that day, unrelated to work, that increased her pain to 10/10, and resulted in her inability to continue working. In addition to this, petitioner had long standing preexisting problems with her low back and radiculopathy dating back as far as 2000 or 2003, per petitioner's own history to her healthcare providers. Even when petitioner presented for treatment after the injury on 10/7/13 she gave a history of low back pain for years. The arbitrator finds it significant that when petitioner presented to Dr. Kube she admitted that she sustained a severe exacerbation to her low back on 5/2/14 and had not been able to work since then. The arbitrator also finds it significant that petitioner reported to Dr. Kube that she had shooting pains down her legs, worse on the left, since a lifting injury on 2004. Based on her condition after the injury on 5/3/14 Dr. Kube performed some injections that seemed to improve her condition until she sustained an intervening accident on 9/9/14 when she had a motor vehicle accident that resulted in increased symptomatology in her low back.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner's current condition of ill-being as it relates to her left shoulder is causally related to the injuries on 10/7/13 and 12/17/13 through 1/31/14, and the petitioner's current condition of ill-being as it relates to her low back is causally related to the injuries on 10/7/13 and 12/17/13 through 5/2/14.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found the petitioner's current condition of ill-being as it relates to her left shoulder is causally related to the injuries on 10/7/13 and 12/17/13 through 1/31/14, and the petitioner's current condition of ill-being as it relates to her low back is causally related to the injuries on 10/7/13 and 12/17/13 through 5/2/14, the arbitrator finds the respondent shall pay reasonable and necessary medical services for petitioner's left shoulder from 10/7/13 through 1/31/14, and for petitioner's low back from 10/7/13 through 5/2/14, 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.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner is alleging she is entitled to temporary total disability benefits from 5/4/14 through 1/26/16. Having found the petitioner's current condition of ill-being as it relates to her left shoulder is causally related to the injuries on 10/7/13 and 12/17/13 through 1/31/14, and the petitioner's current condition of ill-being as it relates to her low back is causally related to the injuries on 10/7/13 and 12/17/13 through 5/2/14, and petitioner's request for temporary total disability benefits are after these dates, the arbitrator finds the petitioner is not entitled to any temporary total disability benefits.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

As a result of the injuries petitioner sustained on 10/7/13 and 12/17/13, petitioner sustained a strain of her left shoulder and a strain of her low back.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 6% of the left upper extremity, and 4% of the whole person, for petitioner's left shoulder injury as determined by Dr. Rhode, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The doctor bases this opinion on the fact that this impairment rating is based on petitioner's current condition of ill-being on 8/5/15 as it relates to petitioner's left shoulder. Because the arbitrator found the causal connection between petitioner's left shoulder and the injuries on 10/7/13 and 12/17/13 were only causally related through 1/31/14, the Arbitrator therefore gives little 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 recovery support tech at the time of the accident and that she continued in that capacity as long as the causal connection between her injuries and the accidents on 10/7/13 and 12/17/13 existed through 5/2/14. In fact petitioner continued working her full duty job for respondent until she sustained a severe exacerbation of her preexisting low back injury on the morning of 5/3/14, unrelated to her work, and could not longer work after that date. Because of this, the Arbitrator therefore gives little weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 55 years old at the time of the accident. Because all doctors have opined that petitioner can work, and petitioner was working full duty

without restrictions prior to her severe exacerbation of her low back on 5/3/14, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no credible evidence was offered to support a finding that petitioner's future earnings will be impacted in any way by these injuries. 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 as a result of the injuries on 10/7/13 and 12/17/13 petitioner sustained a strain of both her left shoulder and low back. She also sustained a temporary aggravation of her preexisting long standing left shoulder and low back conditions that date at least as far back as 2003. Petitioner's last mention of any left shoulder pain before seeing Dr. Hoffman on 5/7/14 was on 12/18/13 when she rated it at a 4/10. No mention was made of it on 1/22/14, 1/31/14 or 2/6/14. Petitioner's last mention of any low back pain before presenting to the emergency room on 5/3/14 with a severe exacerbation of her low back pain, unrelated to work, was on 1/31/14 when she rated her pain at a 4/10, and on 2/6/14 when she reported pain, but her neurological exam was normal. 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 4% loss of use of her person as a whole pursuant to §8(d)2 of the Act, for the injuries she sustained to her left shoulder and low back as a result of the accidents on 10/7/13 and 12/17/13.

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

RUSSEL RIEDLE,

Petitioner,

vs.

NO: 13 WC 025266

CHESTER MENTAL HEALTH CENTER,

18IWCC0175

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) of the Act having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses and TTD 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.

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

18IWCC0175

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, as the above claim is against State of Illinois, this Decision and Opinion on Review of the Commission is not subject to judicial review.

DATED: MAR 22 2018
KWL/mav
O: 03/06/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

RIEDLE, RUSSELL
Employee/Petitioner

Case# **13WC025266**
15WC000529

CHESTER MENTAL HEALTH CENTER
Employer/Respondent

18IWCC0175

On 9/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4075 FISHER KERHOVER & COFFEY
JASON COFFEY
1300 1/2 SWANWICK ST POB 191
CHESTER, IL 62233

0588 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 10
CARBONDALE, IL 62901

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

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

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

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

SEP 25 2017

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

18IWCC0175

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)/8(a)

RUSSELL RIEDLE
Employee/Petitioner

v.

CHESTER MENTAL HEALTH CENTER
Employer/Respondent

Case # 13 WC 025266

Consolidated cases: 15 WC 00529

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 23, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$45,460.71**; the average weekly wage was **$874.24**.

On the date of accident, Petitioner was **46** years of age, ***married*** 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 for any medical expenses paid prior to hearing under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has failed to prove, by a preponderance of the evidence, that his current condition is causally related to the July 23, 2012 accident. The Petitioner's cervical condition was initially causally related to the accident, but the causal relationship ended as of October 23, 2012.

Respondent shall pay reasonable and necessary causally related medical expenses of Chester Memorial Hospital, any expenses incurred via treatment at the Chester Mental Health facility, as well as the treatment of Dr. Hunter through 10/23/12, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of for any awarded medical benefits that have been paid prior to hearing pursuant to Sections 8(a), 8(j) and 8.2 of the Act, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

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

Signature of Arbitrator

September 13, 2017
Date

SEP 25 2017

STATEMENT OF FACTS

The Petitioner works for Respondent as a Security Therapy Aide I. He had worked at the Chester Mental Health Center for 3.5 years before moving to the Alton Mental Health Center for the last 26 months. The job involves monitoring patient behaviors and actions, which includes securing and restraining patients from harming themselves and others, and so they can receive medications. He testified he would have to physically restrain patients "quite often", estimating approximately 10 times a week, at Chester, a maximum security facility, and would do this less often now at minimum security Alton.

On 7/23/12, Petitioner was sitting with a coworker at the end of a hallway where patients were not allowed. A patient came into that area and struck the Petitioner in the left side of the face and "rocked my world and injured my neck." He immediately sought treatment at Chester Memorial Hospital, noting that the immediate concern at that time was his jaw. The report from that facility references that Petitioner was punched in the face and complained of left jaw pain, with no neck pain. However, a triage report notes "Lt side jaw hurts and neck." CT scan of the jaw showed no definite fractures but possible mild soft tissue swelling along the anterior aspect of the chin and anterior maxillary spine. Petitioner was discharged with pain medication and advised to follow up at Chester Clinic On Call. (Px1).

Respondent submitted injury report documentation consistent with the Petitioner's description of the 7/23/12 incident. The Chester facility physician recorded that Petitioner was struck in the left jaw and temple areas, that there were contusions, and notes a neck strain. A Staff Injury Summary indicated complaints of the left jaw and forearm, noting a patient hit him repeatedly. A "Demands of the Job" form analysis of the Petitioner's physical duties was also included in this exhibit. (Rx1).

Petitioner next sought treatment with chiropractor Dr. Hunter for his neck. The records reflect Petitioner treated there from 7/24/12 through 10/23/12. The initial report indicates Petitioner was punched twice in the left side of the head, noting no neck x-rays were taken at the ER. He reported discomfort bilaterally in the cervical spine and cervical dorsal/thoracic areas with pain levels between 6/10 and 9/10. Petitioner was diagnosed as having cervical and thoracic strains and underwent chiropractic manipulations and therapy. He was advised to stay off work for a week and to avoid heavy lifting, and after noting good but not complete improvement, he was released to unrestricted duty on 7/31/12. However, the 8/6/12 report notes he was performing some light duty work. On 8/8/12, Petitioner reported he had been kicked in the neck at work. On 8/14/12 he reported being involved in two altercations with inmates/patients the prior day. Subsequent to this date Petitioner generally complained of ongoing pain at 2/10 to 4/10 with neck stiffness. On 8/23/12 he underwent unrelated surgery to remove a lap band in his stomach, after which he returned to work on 9/7/12. By 10/3/12, Petitioner was

indicating significant improvement. He was released at MMI on 10/23/12 with notation of 95% improvement. (Px2).

The Respondent obtained a utilization review regarding the ongoing chiropractic care from chiropractor Dr. Coleman. Given no "documented, measurable functional" improvement, no more than 6 visits were medically necessary. (Rx6).

Petitioner testified he continued to have pain after his treatment with Dr. Hunter ended in October 2012. He testified that he initially missed 5 days of work after the injury, and over the next 4 years missed only two days due to neck pain, while continuing to work full duty. Petitioner agreed he was paid service connected time for the initial 5 days he was off work.

On 6/10/13, Petitioner testified that he was bringing a patient into the restraint room. Two other workers got the patient onto the bed, and when Petitioner went to put his torso over the patient's thighs to prevent him from kicking, the patient pulled his legs up first and then brought them both down onto Petitioner's head and neck.

Neither party submitted any facility injury report documentation with regard to this alleged accident. Petitioner testified he again initially sought chiropractic treatment, however no record of such treatment was noted by the Arbitrator in the evidentiary record.

Petitioner testified he then sought treatment with Dr. Gornet due to ongoing pain. He testified that he had difficulty getting treatment approved through the Respondent's insurer, and after about six months indicated he was obtaining a lawyer and was going to see his doctors at St. Louis Orthopedics.

The initial report of Dr. Gornet is dated 3/25/14, at which time the Petitioner reported pain in the neck into the left trapezius and into the arm to the elbow, as well as left-sided headaches. He denied any significant right-sided symptoms. He indicated the problem began on 7/24/12 when he was punched in the jaw, with multiple subsequent altercations with patients at work "with the most memorable being 6/10/13 with a subsequent additional injury in August 2013 in which he was attacked, as well as in December of 2013, when he was struck on the chin by a patient's elbow." Petitioner felt all of the incidents exacerbated his original July 2012 symptoms and that he was progressively worsening. (Px3, Depx2).

Dr. Gornet reported cervical x-rays showed no significant bony problems or degeneration other than some subtle C5/6 changes. He noted the shoulder symptoms could be due to a cervical or shoulder pathology, and prescribed cervical MRI. He opined that the current symptoms were causally related to the July 2012 injury as well as the subsequent aggravations from multiple altercations at work. Petitioner was advised to continue working full duty. (Px3, Depx2).

The 5/12/14 cervical MRI reflected: at C2/3, a diffuse disc bulge with minimal canal stenosis, a right disc protrusion and asymmetric right facet arthropathy contributing to moderate right foraminal stenosis; at C3/4, a diffuse bulge and left foraminal disc protrusion with mild canal, moderate left foraminal and mild right foraminal stenosis; normal findings at C4/5; at C5/6, a broad-based left disc protrusion contributing to moderate left foraminal stenosis; at C6/7, a broad-based left foraminal and mild central disc protrusion with mild left foraminal stenosis. (Px3, Depx3).

At a 5/12/14 follow up, Dr. Gornet's reading of the films indicated a right C3/4 annular tear, a right C6/7 foraminal herniation, and a more significant left disc problem at C5/6 with a smaller left C6/7 protrusion. Noting the films "do tend to correlate" with the symptoms, he recommended conservative treatment but noted:

"This is a quality of life issue." Noting problems at three levels including C3/4, he recommended C5/6 and C6/7 treatment first in the form of injections with Dr. Boutwell. Full duty was continued. (Px3, Depx2).

Following left C5/6 (5/28/14) and C6/7 (6/11/14) epidurals, Petitioner reported "dramatic improvement" with them to Dr. Gornet on 7/10/14. Dr. Gornet prescribed disc replacement surgery at both levels, but noted he wanted to determine if C3/4 played a role in the symptoms. While he continued full duty, Gornet's note states: "Pt on light duty for knee." (Px3, Depx2).

Dr. Boutwell performed the C3/4 epidural on 7/16/14. On 9/15/14, Dr. Gornet opined there was disc pathology at all three noted levels on the left per a foraminal MRI view, but, without explanation, now was recommending Petitioner try to continue to live with his symptoms and released him to full duty and a follow up in 2 to 3 months. (Px3, Depx2 & 3).

The Petitioner testified the injections helped for about 6 days before his condition returned to its baseline.

Petitioner underwent a Section 12 examination with Dr. Petkovich on 1/28/15 at the request of the Respondent. He noted he did not have the Petitioner's records from the ER or Dr. Gornet for review, or the MRI films. Petitioner reported persistent pain in the left neck and paraspinals since 7/23/12, when he was punched in the left face without radicular symptoms. Petitioner had tenderness to palpation in the areas he complained of and pain at the extremes of range of motion. Neurologic exam was normal. X-rays taken that day reflected mild degenerative changes at C5/6. Pending review of additional records, Dr. Petkovich diagnosed a cervical strain which occurred on 7/23/12, and noted the objective physical findings were consistent with the objective physical findings. While he couldn't opine as to MMI pending review of further records, he did indicate he believed the cervical strain had resolved despite ongoing symptoms, and that Petitioner did not require work restrictions. (Rx2).

Dr. Petkovich prepared an addendum report on 2/18/15 following his review of the 5/12/14 MRI and the records of Dr. Gornet. He indicated that the MRI reflected some degenerative disc changes at C2 to C4 and C5 to C7 with some lateral protrusion to the left causing some foraminal stenotic changes. He opined that Petitioner's cervical strain had resolved, that he otherwise had degenerative conditions that were not caused, aggravated or accelerated by the work injury, and that he had reached MMI. He noted he was in agreement with Dr. Gornet's 9/15/14 report recommending that Petitioner live with his condition and continue to work full duty. (Rx3).

The testimony of Dr. Petkovich, a board certified orthopedic surgeon and independent medical examiner, was obtained via deposition on 5/14/15. He testified that he stopped performing spinal surgery 3 to 4 years prior due to an eye injury, but still performs other general orthopedic surgeries while his medical/legal practice has grown to 15% to 25%. His testimony was consistent with his initial reports with regard to complaints and exam findings. He testified that the cervical MRI showed degenerative disc disease from C2 to C4 and C5 to C7, with some disc protrusions bilaterally and some lateral foraminal stenotic changes, but no acute findings. It was his opinion that the degenerative findings were longstanding and predated the 7/23/12 accident (they had been "going on for a number of years"), and that while the Petitioner sustained a cervical strain as a result of that accident, he did not aggravate or accelerate the condition due to the accident. He determined Petitioner had reached maximum medical improvement (MMI), and that he did not require surgery or work restrictions. (Rx5).

Dr. Petkovich testified that Petitioner had a normal neurologic examination with no evidence of nerve root problems or impingement. He did testify that disc replacement, as well as fusion, may be indicated with degenerative disc disease when the patient's symptoms become intolerable. Petitioner did not describe

intolerable pain during when he examined him. Dr. Petkovich agreed that Dr. Gornet's 9/15/14 report indicated Gornet advised the Petitioner to continue working full duty and to live with his symptoms. (Rx5).

On cross exam, Dr. Petkovich agreed that Petitioner indicated he was punched in the face without warning on 7/23/12. He agreed that MRI films showed cervical annular fissuring, as well as some disc protrusions which resulted in lateral foraminal impingement. He agreed that he did not see any medical records which predated 7/23/12 indicating neck problems. While he did not recommend any further treatment for Petitioner, he testified that "I think that he does have some pain." However, he testified that this pain was related to discomfort from degeneration, "like most people his age", and that he could use over-the-counter analgesics when needed. Dr. Petkovich agreed he has performed disc replacement and fusion surgeries in the past. On redirect examination, he testified that the Petitioner did have cervical disc protrusions, but not to the extent that he would call them herniations, noting that the MRI report also did not reference any disc herniations. (Rx5).

Petitioner then did not return to Dr. Gornet until 4/4/16, subsequent to the deposition of Dr. Petkovich. The report stated: "He was still having neck pain and stiffness and pain with headaches. He had pain into both shoulders, particularly the left shoulder and left arm." Exam noted no focal neurological deficit, but Petitioner complained of radicular pain into the left arm. Petitioner asked Dr. Gornet to review the report of Dr. Petkovich, and Dr. Gornet noted that Petkovich's opinion that the cervical MRI changes were degenerative "seems to be a relatively common scenario" for him. Dr. Gornet continued to opine that Petitioner's symptoms were related to the 7/24/12 incident as well as subsequent 6/10/13 and 8/13 incidents. Petitioner indicated his symptoms were not tolerable and that he was taking a lot of Tylenol. Dr. Gornet prescribed updated MRI and indicated he had no problem with Petitioner continuing to work full duty. (Px3, Depx2).

The report from the updated 6/6/16 cervical MRI indicated normal discs at C2/3, C4/5 and C7/T1. At C3/4, a broad-based herniation resulted in at least mild canal stenosis and some foraminal encroachment, particularly on the right, without definite impingement. This is what was noted in the body of the report, while the impression section indicated the herniation was slightly more prominent on the left. At C5/6, there was a left-sided herniation extending towards the exiting left C6 nerve root. At C6/7, there was a questionable left-sided disc fragment or small protrusion, though that could have been artefactual. Clinical correlation was advised. (Px3, Depx3)

On 6/6/16, after reviewing the updated MRI, Dr. Gornet recommended C3/4 and C5/6 disc replacement surgery, noting he would first want a CT/myelogram. He noted that the C5/6 level herniation correlated well with the left-sided neck pain into the head and left arm. (Px3, Depx3).

Dr. Gornet testified via deposition on 11/14/16. He is a board certified orthopedic surgeon. He testified consistent to his initial report and noted his MRI findings. Dr. Gornet testified that Petitioner had "dramatic" improvement with the initial injections, though he felt C3/4 might still be playing a role. Following the C3/4 injection, Dr. Gornet indicated on 9/15/14 that Petitioner again had good relief, but that it unfortunately only lasted for 4 or 5 days, "so, at that point I told him, try to live with his symptoms, take an inventory, determine how much it affects him, continue to work full duty, and then we would monitor him to determine whether or not he felt he needed further treatment." He noted Petitioner then did not return for a year and a half on 4/4/16. Petitioner reported no intervening injuries, and Dr. Gornet opined his condition at that time remained causally related to the July 2012 work accident. (Px5).

Dr. Gornet criticized Dr. Petkovich's opinion that Petitioner's current condition was degenerative and not causally related to the accident. He testified that the load applied to Petitioner's cervical spine when he was punched is no different than a whiplash injury, that there are clear structural problems indicated in the MRI

which correlate with Petitioner's symptoms, and that "we know that those objective findings are the source of his symptoms because we were able to relieve those symptoms by targeted injections." He did testify that Petitioner had been punched and elbowed in the face, and that's when his symptoms began. Dr. Gornet noted Petitioner's condition of well-being was good until the 7/12 incident, after which his condition changed, and "simply put, there is no other plausible explanation than to associate his current neck pain, headaches, left trapezius, left shoulder, left arm symptoms with the objective pathology seen." He agreed the right-sided annular tear was not responsible for Petitioner's left-sided symptoms, but that it could be contributing to his neck pain and headaches. (Px5).

As Petitioner was "becoming again" symptomatic, and he had been treated conservatively "for years", he switched gears to recommend a more permanent treatment, C3/4 and C5/6 anterior disc replacement surgery, which he opined to be causally related to the 7/12 accident. Dr. Gornet testified that the Petitioner still may need an additional foraminotomy surgery at C3/4, which may not be addressable via the anterior approach, in the future if his trapezius symptoms didn't resolve with the disc replacement. (Px5).

On cross exam, Dr. Gornet did not believe that further therapy or injections would provide Petitioner with any sustained relief, probably less than a 30% chance, but testified he would not have a problem with attempting it. He did not know why the Petitioner didn't return after 9/14 until 6/16, noting Petitioner was having some heart problems around this time, and that he didn't know if anything else precluded him from returning. He did not order any shoulder work-up because the dramatic symptom improvement with cervical injections led to the cervical diagnosis. Whether the Petitioner reported the 7/12 accident as being on 7/23/12 or 7/24/12 was irrelevant to his opinion so long as the Petitioner was actually punched on that date as described. (Px5).

Following Dr. Gornet's deposition, an additional 11/30/15 addendum was obtained from Dr. Petkovich based on Petitioner's claim of a second accident on 6/10/13. Based on a review of additional medical records, Petitioner reported the 6/10/13 incident involved redirecting a patient when he put his arm up and felt a pull in his right neck, after which he saw a physician at the Chester Mental Health facility and was diagnosed with a strain. Dr. Petkovich noted Petitioner never reported this second incident when he saw him on 1/21/15, and that based on the report he reviewed, he suffered a cervical strain at that time which had resolved prior to the 1/21/15 visit. (Rx4).

Petitioner testified that he wants to undergo the surgery recommended by Dr. Gornet. Petitioner indicated he has had no other injuries outside of work since 7/23/12, and had no prior surgeries or major neck pain.

On cross examination, Petitioner agreed the ER referred him to Chester Clinic upon discharge, but testified he didn't follow up there because he lives in O'Fallon, Illinois. Petitioner testified he had never treated with Dr. Hunter before 7/23/12, but had undergone chiropractic neck treatment as a part of full body chiropractic treatment for "general wellness", noting he had seen several chiropractors to the right one. He couldn't recall the last time he had such treatment prior to 7/23/12, but agreed it was in the year prior to the accident.

Petitioner has a primary care provider, Dr. Schular, and testified that, to his recall, he had not seen him for neck complaints before 7/23/12. Asked about whether he had any treatment between his last visit with Dr. Hunter in October 2012 and his first visit with Dr. Gornet in March 2014, Petitioner testified: "I believe I went to the VA for pain medicine." He did not recall ever treating at the VA for neck pain prior to 7/23/12.

Petitioner said he heard about Dr. Gornet because he had treated with Dr. Gross at the same facility, and he was aware that he treats professional athletes.

Petitioner testified that he did not see Dr. Gornet between 9/15/14 and 4/16 because he was waiting to get in to see Section 12 examiner, Dr. Petkovich. He saw no one physician in that time period, other than possibly Dr. Boutwell for injections.

Petitioner agreed that his duties at Alton are similar to what they were at Chester. He testified he has been able to do his job at Alton "with great difficulty", noting he takes a lot of Naproxen and Tylenol. He testified that he is not able to drive patients at work because he does sometimes take Tramadol.

CONCLUSIONS OF LAW

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

For the reasons indicated below, the Arbitrator finds that the Petitioner's current condition is not causally related to the 7/23/12 accident. The causal relationship of Petitioner's cervical condition ended as of the 10/23/12 MMI determination of Dr. Hunter.

There is no medical evidence that the Petitioner sought any further treatment after 10/23/12 until visiting Dr. Gornet on 3/25/14, a period of about 17 months. He testified that he obtained treatment with the Veteran's Administration in this gap period, but Petitioner produced no evidence to support this claimed treatment. As such, the treatment cannot be verified, nor can any alleged complaints at that time or diagnoses. The gap in treatment in this case is significant in the Arbitrator's view, particularly where the last treatment in October 2012 indicated Petitioner had 95% improvement. The Petitioner then went on to continue working full duty, testifying he missed only a couple days of work due to is neck after his initial 5 days off. While the Petitioner testified that he had ongoing problems after Dr. Hunter's release, the evidence, or lack thereof, does not support his claim.

The Arbitrator found the opinion of Dr. Petkovich to be more persuasive than that of Dr. Gornet in this case. First, the Petitioner agreed he had prior chiropractic treatment for his neck. He testified that he had such treatment as part of "full body" care. However, as with the alleged VA records, these chiropractic records were not submitted.

Dr. Petkovich felt Petitioner's cervical condition was degenerative and preexisting. Based upon the medical records, Petitioner imaging studies show disc desiccation caused by degeneration. As noted, Petitioner's prior neck treatment supports this finding.

Meanwhile, Dr. Gornet testified that the Petitioner's condition is related to multiple accidents that occurred subsequent to 7/23/12. However, he does not relate what specifically occurred on these dates. He does note in one incident the Petitioner was elbowed in the face, but there is no claimed accident related to this alleged event.

Dr. Gornet initially recommended surgery at two cervical levels, then recommended Petitioner live with his symptoms, then recommended surgery at one of the same levels he previously had recommended surgery but along with surgery at a different third level. He testified that the injections performed supported his identification of surgical levels. However, these identified levels changed between his first and second surgical recommendations. Further, between these two surgical recommendations, Dr. Gornet opined that Petitioner should live with his condition and continue full duty employment.

Overall, it appears that the Petitioner was injured on 7/23/12, but that this injury involved an aggravation of preexisting degenerative disc disease, and that this aggravation ended as of 10/23/12, when the Petitioner had reportedly obtained 95% improvement, and after which he sought no further treatment for 17 months. Given these facts, and the failure to offer supporting documentation for any alleged treatment over those 17 months, he has failed to prove causation.

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

The Arbitrator finds that the Petitioner is entitled to the medical expenses from the initial ER visit at Chester Memorial Hospital, any expenses incurred via treatment at the Chester Mental Health facility, as well as the treatment of Dr. Hunter through 10/23/12. (See Px4). While the Respondent submitted a utilization review to defend against the ongoing treatment of Dr. Hunter, the evidence indicates that the treatment resulted in the Petitioner improving by 95% as of 10/23/12, and allowed him to return to work with no further treatment. As such, the Arbitrator believes the greater weight of the evidence indicates the treatment of Dr. Hunter was reasonable and necessary within the meaning of Section 8(a) of the Act.

The Respondent is entitled to credit for any of these awarded medical expenses that were paid prior to hearing pursuant to Sections 8(a), 8(j) and 8.2 of the Act. In accepting such credit, the Respondent shall hold the Petitioner harmless with regard to these awarded expenses.

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

Based on the Arbitrator's finding that the Petitioner has failed to prove a causal connection, this issue is 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

RUSSELL RIEDLE,

Petitioner,

vs. NO: 15 WC 000529

CHESTER MENTAL HEALTH CENTER,

18IWCC0176

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Decision of the Arbitrator only to correct a scrivener's error found on page two of the Decision of the Arbitrator. Under "Order," it is written, "The Arbitrator finds that the Petitioner has failed to prove, by a preponderance of the evidence, that his current condition is causally related to the June 10, 2015, accident." The parties, in the Request for Hearing, stipulated to the accident occurring on June 10, 2013. The Commission, therefore strikes "2015" and replaces it with "2013."

18IWCC0176

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 9, 2016 is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner failed to prove, by a preponderance of the evidence, that his current condition is causally related to the June 10, 2015, accident, and that, as provided in §19(b) of the Act, this Decision and Opinion on Review in no instance shall be a bar to a further hearing and determination 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.

Pursuant to §19(f)(1) of the Act, as the above claim is against State of Illinois, this Decision and Opinion on Review of the Commission is not subject to judicial review.

DATED: MAR 2 2 2018
KWL/mav
O: 03/06/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

RIEDLE, RUSSELL
Employee/Petitioner

Case# 15WC000529

13WC025266

CHESTER MENTAL HEALTH CENTER
Employer/Respondent

18IWCC0176

On 9/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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CHESTER, IL 62233

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BUREAU OF RISK MANAGEMENT
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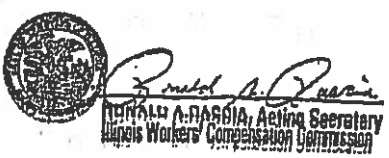
SPRINGFIELD, IL 62794-9208

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

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

SEP 25 2017



Ronald A. Rascia, Acting Secretary

18IWCC0176

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)/8(a)

RUSSELL RIEDLE
Employee/Petitioner

v.

CHESTER MENTAL HEALTH CENTER
Employer/Respondent

Case # 15 WC 00529

Consolidated cases: 13 WC 25266

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

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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 10, 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 **$45,460.71**; the average weekly wage was **$874.24**.

On the date of accident, Petitioner was **47** years of age, ***married*** 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 for any medical expenses paid prior to hearing under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has failed to prove, by a preponderance of the evidence, that his current condition is causally related to the June 10, 2015 accident.

No benefits are awarded.

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

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

Signature of Arbitrator

September 13, 2017
Date

SEP 25 2017

STATEMENT OF FACTS

The Petitioner works for Respondent as a Security Therapy Aide I. He had worked at the Chester Mental Health Center for 3.5 years before moving to the Alton Mental Health Center for the last 26 months. The job involves monitoring patient behaviors and actions, which includes securing and restraining patients from harming

themselves and others, and so they can receive medications. He testified he would have to physically restrain patients "quite often", estimating approximately 10 times a week, at Chester, a maximum security facility, and would do this less often now at minimum security Alton.

On 7/23/12, Petitioner was sitting with a coworker at the end of a hallway where patients were not allowed. A patient came into that area and struck the Petitioner in the left side of the face and "rocked my world and injured my neck." He immediately sought treatment at Chester Memorial Hospital, noting that the immediate concern at that time was his jaw. The report from that facility references that Petitioner was punched in the face and complained of left jaw pain, with no neck pain. However, a triage report notes "Lt side jaw hurts and neck." CT scan of the jaw showed no definite fractures but possible mild soft tissue swelling along the anterior aspect of the chin and anterior maxillary spine. Petitioner was discharged with pain medication and advised to follow up at Chester Clinic On Call. (Px1).

Respondent submitted injury report documentation consistent with the Petitioner's description of the 7/23/12 incident. The Chester facility physician recorded that Petitioner was struck in the left jaw and temple areas, that there were contusions, and notes a neck strain. A Staff Injury Summary indicated complaints of the left jaw and forearm, noting a patient hit him repeatedly. A "Demands of the Job" form analysis of the Petitioner's physical duties was also included in this exhibit. (Rx1).

Petitioner next sought treatment with chiropractor Dr. Hunter for his neck. The records reflect Petitioner treated there from 7/24/12 through 10/23/12. The initial report indicates Petitioner was punched twice in the left side of the head, noting no neck x-rays were taken at the ER. He reported discomfort bilaterally in the cervical spine and cervical dorsal/thoracic areas with pain levels between 6/10 and 9/10. Petitioner was diagnosed as having cervical and thoracic strains and underwent chiropractic manipulations and therapy. He was advised to stay off work for a week and to avoid heavy lifting, and after noting good but not complete improvement, he was released to unrestricted duty on 7/31/12. However, the 8/6/12 report notes he was performing some light duty work. On 8/8/12, Petitioner reported he had been kicked in the neck at work. On 8/14/12 he reported being involved in two altercations with inmates/patients the prior day. Subsequent to this date Petitioner generally complained of ongoing pain at 2/10 to 4/10 with neck stiffness. On 8/23/12 he underwent unrelated surgery to remove a lap band in his stomach, after which he returned to work on 9/7/12. By 10/3/12, Petitioner was indicating significant improvement. He was released at MMI on 10/23/12 with notation of 95% improvement. (Px2).

The Respondent obtained a utilization review regarding the ongoing chiropractic care from chiropractor Dr. Coleman. Given no "documented, measurable functional" improvement, no more than 6 visits were medically necessary. (Rx6).

Petitioner testified he continued to have pain after his treatment with Dr. Hunter ended in October 2012. He testified that he initially missed 5 days of work after the injury, and over the next 4 years missed only two days due to neck pain, while continuing to work full duty. Petitioner agreed he was paid service connected time for the initial 5 days he was off work.

On 6/10/13, Petitioner testified that he was bringing a patient into the restraint room. Two other workers got the patient onto the bed, and when Petitioner went to put his torso over the patient's thighs to prevent him from kicking, the patient pulled his legs up first and then brought them both down onto Petitioner's head and neck.

Neither party submitted any facility injury report documentation with regard to this alleged accident. Petitioner testified he again initially sought chiropractic treatment, however no record of such treatment was noted by the Arbitrator in the evidentiary record.

Petitioner testified he then sought treatment with Dr. Gornet due to ongoing pain. He testified that he had difficulty getting treatment approved through the Respondent's insurer, and after about six months indicated he was obtaining a lawyer and was going to see his doctors at St. Louis Orthopedics.

The initial report of Dr. Gornet is dated 3/25/14, at which time the Petitioner reported pain in the neck into the left trapezius and into the arm to the elbow, as well as left-sided headaches. He denied any significant right-sided symptoms. He indicated the problem began on 7/24/12 when he was punched in the jaw, with multiple subsequent altercations with patients at work "with the most memorable being 6/10/13 with a subsequent additional injury in August 2013 in which he was attacked, as well as in December of 2013, when he was struck on the chin by a patient's elbow." Petitioner felt all of the incidents exacerbated his original July 2012 symptoms and that he was progressively worsening. (Px3, Depx2).

Dr. Gornet reported cervical x-rays showed no significant bony problems or degeneration other than some subtle C5/6 changes. He noted the shoulder symptoms could be due to a cervical or shoulder pathology, and prescribed cervical MRI. He opined that the current symptoms were causally related to the July 2012 injury as well as the subsequent aggravations from multiple altercations at work. Petitioner was advised to continue working full duty. (Px3, Depx2).

The 5/12/14 cervical MRI reflected: at C2/3, a diffuse disc bulge with minimal canal stenosis, a right disc protrusion and asymmetric right facet arthropathy contributing to moderate right foraminal stenosis; at C3/4, a diffuse bulge and left foraminal disc protrusion with mild canal, moderate left foraminal and mild right foraminal stenosis; normal findings at C4/5; at C5/6, a broad-based left disc protrusion contributing to moderate left foraminal stenosis; at C6/7, a broad-based left foraminal and mild central disc protrusion with mild left foraminal stenosis. (Px3, Depx3).

At a 5/12/14 follow up, Dr. Gornet's reading of the films indicated a right C3/4 annular tear, a right C6/7 foraminal herniation, and a more significant left disc problem at C5/6 with a smaller left C6/7 protrusion. Noting the films "do tend to correlate" with the symptoms, he recommended conservative treatment but noted: "This is a quality of life issue." Noting problems at three levels including C3/4, he recommended C5/6 and C6/7 treatment first in the form of injections with Dr. Boutwell. Full duty was continued. (Px3, Depx2).

Following left C5/6 (5/28/14) and C6/7 (6/11/14) epidurals, Petitioner reported "dramatic improvement" with them to Dr. Gornet on 7/10/14. Dr. Gornet prescribed disc replacement surgery at both levels, but noted he wanted to determine if C3/4 played a role in the symptoms. While he continued full duty, Gornet's note states: "Pt on light duty for knee." (Px3, Depx2).

Dr. Boutwell performed the C3/4 epidural on 7/16/14. On 9/15/14, Dr. Gornet opined there was disc pathology at all three noted levels on the left per a foraminal MRI view, but, without explanation, now was recommending Petitioner try to continue to live with his symptoms and released him to full duty and a follow up in 2 to 3 months. (Px3, Depx2 & 3).

The Petitioner testified the injections helped for about 6 days before his condition returned to its baseline.

Petitioner underwent a Section 12 examination with Dr. Petkovich on 1/28/15 at the request of the Respondent. He noted he did not have the Petitioner's records from the ER or Dr. Gornet for review, or the MRI films. Petitioner reported persistent pain in the left neck and paraspinals since 7/23/12, when he was punched in the left face without radicular symptoms. Petitioner had tenderness to palpation in the areas he complained of and pain at the extremes of range of motion. Neurologic exam was normal. X-rays taken that day reflected mild degenerative changes at C5/6. Pending review of additional records, Dr. Petkovich diagnosed a cervical strain which occurred on 7/23/12, and noted the objective physical findings were consistent with the objective physical findings. While he couldn't opine as to MMI pending review of further records, he did indicate he believed the cervical strain had resolved despite ongoing symptoms, and that Petitioner did not require work restrictions. (Rx2).

Dr. Petkovich prepared an addendum report on 2/18/15 following his review of the 5/12/14 MRI and the records of Dr. Gornet. He indicated that the MRI reflected some degenerative disc changes at C2 to C4 and C5 to C7 with some lateral protrusion to the left causing some foraminal stenotic changes. He opined that Petitioner's cervical strain had resolved, that he otherwise had degenerative conditions that were not caused, aggravated or accelerated by the work injury, and that he had reached MMI. He noted he was in agreement with Dr. Gornet's 9/15/14 report recommending that Petitioner live with his condition and continue to work full duty. (Rx3).

The testimony of Dr. Petkovich, a board certified orthopedic surgeon and independent medical examiner, was obtained via deposition on 5/14/15. He testified that he stopped performing spinal surgery 3 to 4 years prior due to an eye injury, but still performs other general orthopedic surgeries while his medical/legal practice has grown to 15% to 25%. His testimony was consistent with his initial reports with regard to complaints and exam findings. He testified that the cervical MRI showed degenerative disc disease from C2 to C4 and C5 to C7, with some disc protrusions bilaterally and some lateral foraminal stenotic changes, but no acute findings. It was his opinion that the degenerative findings were longstanding and predated the 7/23/12 accident (they had been "going on for a number of years"), and that while the Petitioner sustained a cervical strain as a result of that accident, he did not aggravate or accelerate the condition due to the accident. He determined Petitioner had reached maximum medical improvement (MMI), and that he did not require surgery or work restrictions. (Rx5).

Dr. Petkovich testified that Petitioner had a normal neurologic examination with no evidence of nerve root problems or impingement. He did testify that disc replacement, as well as fusion, may be indicated with degenerative disc disease when the patient's symptoms become intolerable. Petitioner did not describe intolerable pain during when he examined him. Dr. Petkovich agreed that Dr. Gornet's 9/15/14 report indicated Gornet advised the Petitioner to continue working full duty and to live with his symptoms. (Rx5).

On cross exam, Dr. Petkovich agreed that Petitioner indicated he was punched in the face without warning on 7/23/12. He agreed that MRI films showed cervical annular fissuring, as well as some disc protrusions which resulted in lateral foraminal impingement. He agreed that he did not see any medical records which predated 7/23/12 indicating neck problems. While he did not recommend any further treatment for Petitioner, he testified that "I think that he does have some pain." However, he testified that this pain was related to discomfort from degeneration, "like most people his age", and that he could use over-the-counter analgesics when needed. Dr. Petkovich agreed he has performed disc replacement and fusion surgeries in the past. On redirect examination, he testified that the Petitioner did have cervical disc protrusions, but not to the extent that he would call them herniations, noting that the MRI report also did not reference any disc herniations. (Rx5).

Petitioner then did not return to Dr. Gornet until 4/4/16, subsequent to the deposition of Dr. Petkovich. The report stated: "He was still having neck pain and stiffness and pain with headaches. He had pain into both shoulders, particularly the left shoulder and left arm." Exam noted no focal neurological deficit, but Petitioner

complained of radicular pain into the left arm. Petitioner asked Dr. Gornet to review the report of Dr. Petkovich, and Dr. Gornet noted that Petkovich's opinion that the cervical MRI changes were degenerative "seems to be a relatively common scenario" for him. Dr. Gornet continued to opine that Petitioner's symptoms were related to the 7/24/12 incident as well as subsequent 6/10/13 and 8/13 incidents. Petitioner indicated his symptoms were not tolerable and that he was taking a lot of Tylenol. Dr. Gornet prescribed updated MRI and indicated he had no problem with Petitioner continuing to work full duty. (Px3, Depx2).

The report from the updated 6/6/16 cervical MRI indicated normal discs at C2/3, C4/5 and C7/T1. At C3/4, a broad-based herniation resulted in at least mild canal stenosis and some foraminal encroachment, particularly on the right, without definite impingement. This is what was noted in the body of the report, while the impression section indicated the herniation was slightly more prominent on the left. At C5/6, there was a left-sided herniation extending towards the exiting left C6 nerve root. At C6/7, there was a questionable left-sided disc fragment or small protrusion, though that could have been artefactual. Clinical correlation was advised. (Px3, Depx3)

On 6/6/16, after reviewing the updated MRI, Dr. Gornet recommended C3/4 and C5/6 disc replacement surgery, noting he would first want a CT/myelogram. He noted that the C5/6 level herniation correlated well with the left-sided neck pain into the head and left arm. (Px3, Depx3).

Dr. Gornet testified via deposition on 11/14/16. He is a board certified orthopedic surgeon. He testified consistent to his initial report and noted his MRI findings. Dr. Gornet testified that Petitioner had "dramatic" improvement with the initial injections, though he felt C3/4 might still be playing a role. Following the C3/4 injection, Dr. Gornet indicated on 9/15/14 that Petitioner again had good relief, but that it unfortunately only lasted for 4 or 5 days, "so, at that point I told him, try to live with his symptoms, take an inventory, determine how much it affects him, continue to work full duty, and then we would monitor him to determine whether or not he felt he needed further treatment." He noted Petitioner then did not return for a year and a half on 4/4/16. Petitioner reported no intervening injuries, and Dr. Gornet opined his condition at that time remained causally related to the July 2012 work accident. (Px5).

Dr. Gornet criticized Dr. Petkovich's opinion that Petitioner's current condition was degenerative and not causally related to the accident. He testified that the load applied to Petitioner's cervical spine when he was punched is no different than a whiplash injury, that there are clear structural problems indicated in the MRI which correlate with Petitioner's symptoms, and that "we know that those objective findings are the source of his symptoms because we were able to relieve those symptoms by targeted injections." He did testify that Petitioner had been punched and elbowed in the face, and that's when his symptoms began. Dr. Gornet noted Petitioner's condition of well-being was good until the 7/12 incident, after which his condition changed, and "simply put, there is no other plausible explanation than to associate his current neck pain, headaches, left trapezius, left shoulder, left arm symptoms with the objective pathology seen." He agreed the right-sided annular tear was not responsible for Petitioner's left-sided symptoms, but that it could be contributing to his neck pain and headaches. (Px5).

As Petitioner was "becoming again" symptomatic, and he had been treated conservatively "for years", he switched gears to recommend a more permanent treatment, C3/4 and C5/6 anterior disc replacement surgery, which he opined to be causally related to the 7/12 accident. Dr. Gornet testified that the Petitioner still may need an additional foraminotomy surgery at C3/4, which may not be addressable via the anterior approach, in the future if his trapezius symptoms didn't resolve with the disc replacement. (Px5).

On cross exam, Dr. Gornet did not believe that further therapy or injections would provide Petitioner with any sustained relief, probably less than a 30% chance, but testified he would not have a problem with attempting it. He did not know why the Petitioner didn't return after 9/14 until 6/16, noting Petitioner was having some heart problems around this time, and that he didn't know if anything else precluded him from returning. He did not order any shoulder work-up because the dramatic symptom improvement with cervical injections led to the cervical diagnosis. Whether the Petitioner reported the 7/12 accident as being on 7/23/12 or 7/24/12 was irrelevant to his opinion so long as the Petitioner was actually punched on that date as described. (Px5).

Following Dr. Gornet's deposition, an additional 11/30/15 addendum was obtained from Dr. Petkovich based on Petitioner's claim of a second accident on 6/10/13. Based on a review of additional medical records, Petitioner reported the 6/10/13 incident involved redirecting a patient when he put his arm up and felt a pull in his right neck, after which he saw a physician at the Chester Mental Health facility and was diagnosed with a strain. Dr. Petkovich noted Petitioner never reported this second incident when he saw him on 1/21/15, and that based on the report he reviewed, he suffered a cervical strain at that time which had resolved prior to the 1/21/15 visit. (Rx4).

Petitioner testified that he wants to undergo the surgery recommended by Dr. Gornet. Petitioner indicated he has had no other injuries outside of work since 7/23/12, and had no prior surgeries or major neck pain.

On cross examination, Petitioner agreed the ER referred him to Chester Clinic upon discharge, but testified he didn't follow up there because he lives in O'Fallon, Illinois. Petitioner testified he had never treated with Dr. Hunter before 7/23/12, but had undergone chiropractic neck treatment as a part of full body chiropractic treatment for "general wellness", noting he had seen several chiropractors to the right one. He couldn't recall the last time he had such treatment prior to 7/23/12, but agreed it was in the year prior to the accident.

Petitioner has a primary care provider, Dr. Schular, and testified that, to his recall, he had not seen him for neck complaints before 7/23/12. Asked about whether he had any treatment between his last visit with Dr. Hunter in October 2012 and his first visit with Dr. Gornet in March 2014, Petitioner testified: "I believe I went to the VA for pain medicine." He did not recall ever treating at the VA for neck pain prior to 7/23/12.

Petitioner said he heard about Dr. Gornet because he had treated with Dr. Gross at the same facility, and he was aware that he treats professional athletes.

Petitioner testified that he did not see Dr. Gornet between 9/15/14 and 4/16 because he was waiting to get in to see Section 12 examiner, Dr. Petkovich. He saw no one physician in that time period, other than possibly Dr. Boutwell for injections.

Petitioner agreed that his duties at Alton are similar to what they were at Chester. He testified he has been able to do his job at Alton "with great difficulty", noting he takes a lot of Naproxen and Tylenol. He testified that he is not able to drive patients at work because he does sometimes take Tramadol.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner has failed to prove that his current condition is related to the 6/10/13 accident.

Given the parties have stipulated to the issue of accident, the Arbitrator must assume that the Petitioner reported the incident to the Respondent. However, while it was for the consolidated case involving a 7/23/12 accident, documentation of this incident was not submitted into evidence. Thus, there is no specificity of what the Petitioner may have complained of physically at that time.

This is compounded by the fact that there is no evidence in the record of the Petitioner seeking treatment for this alleged injury, at least not prior to a 3/25/14 visit to Dr. Gornet, over nine months later. At that visit, the Petitioner did not report anything to the doctor about this specific incident, other than it being the most memorable of multiple altercations at work. The specific incident was not described by Dr. Gornet in his report of in his testimony. Gornet at one point notes Petitioner reported being elbowed, but per the Petitioner's testimony, that was not the case on 6/10/13.

Given the Petitioner had prior problems with his neck, and no treatment related to this 6/10/13 incident, the Arbitrator finds that the preponderance of the evidence indicates the Petitioner has failed to prove a causal relationship of his cervical condition to the 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:

Based on the Arbitrator's finding that the Petitioner has failed to prove a causal connection, this issue is moot.

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

Based on the Arbitrator's finding that the Petitioner has failed to prove a causal connection, this issue is moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL MARTIN,

Petitioner,

vs. NO: 14 WC 38562

STATE OF ILLINIOIS,
DEPARTMENT OF HUMAN SERVICES,

18IWCC0177

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission views the evidence differently than the Arbitrator and disagrees with the Arbitrator's Conclusions of Law and Findings regarding accident, causal connection, medical expenses and permanent partial disability. The Commission, after considering the entire record, reverses the Decision of the Arbitrator to find that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment with Respondent on October 10, 2014. In support of the Commission's Decision, the Commission finds the following:

Findings of Fact and Conclusions of Law

Petitioner testified when he moved his desk on October 10, 2014, he "felt a pop" in his low back. (T, p. 10) There were no witnesses to the alleged incident, even though Petitioner reported Vince Bhatnager was a witness. Bhatnager was out of the office on the 10th. (Rx1)

Petitioner also testified when he was leaving on the 10th he ran into a co-worker, Al and he mentioned "hey I was moving my desk and I felt a pop. And I was like I feel fine except just a pop you know that moment." (T, p. 15) Petitioner did not report an accident to his supervisor that day. In fact, Petitioner waited seventeen days to report he injured his back. Petitioner had, however, filed a Union Grievance on or before October 10, 2014 because his supervisor asked him to move his desk. (Px2)

Petitioner did not seek any medical consult until twelve days later. Petitioner testified he first sought medical treatment after the alleged incident when he went for a chiropractic adjustment on October 22, 2014. He returned to the chiropractor on October 23, 2014. The chiropractor's records contain no history of a work incident on either date, however the chiropractor provided an off-work note that Petitioner presented to his supervisor on the 22nd. (Rx3, Rx2)

Petitioner testified he previously sought treatment with Chatham Chiropractic clinic for adjustments on a regular basis prior to the treatments on the October 22, 2014 and October 23, 2014. Petitioner testified he could not recall the last time he had an adjustment before the alleged injury. The chiropractor would adjust the neck, shoulders, spine, and hips similar to adjustments Petitioner received while in the Air Force, when he played college basketball. (T, pp. 13, 17-18) He also testified he had chronic pain, "from being a college athlete and stuff." (T, p. 18)

Petitioner next sought medical treatment with Dr. VanFleet on October 24, 2014. Petitioner testified he had no appointment. He "just showed up" and asked, "can I see someone?" Dr. VanFleet's October 24, 2014 Spine Sheet handwritten by Petitioner requested the "Date of Injury" and Petitioner responded "2 weeks ago." In response to "Date of first episode of pain" Petitioner responded "1 week ago." Therefore, the Petitioner's first episode of pain according to Dr. VanFleet's intake sheet was October 17, 2014.

The Spine Sheet also asked to "state in your own words how the injury happened and what you felt at the time." The Petitioner wrote: "moving desk at work and noticed a slight pain." The Commission finds there is a significant discrepancy between "noticed a slight pain" and Petitioner's testimony he "felt a pop. Petitioner documented he had taken Ibuprofen/Motrin/Advil for 2 days and Naproxen for 3 days which corresponds with Petitioner's history of the first episode of pain one week prior on the 17th.

The intake sheet also required an answer to "have you ever had back pain or neck pain prior to this injury? Petitioner responded "No" which was not truthful. He testified he never had the pain he experienced when he got injured, however, he had chronic pain. (T, p. 18)

Petitioner never reported that he felt a "pop" in his back when he moved the desk in any initial medical records. The first documented report of Petitioner feeling a "pop" in his back was three weeks after the desk incident. The initial therapy notes on October 31, 2014 document that Petitioner was at work and moved his desk and while he was lifting it felt a pop in the back; over the next couple of days the back started to get worse with tingling down the left leg and increased back pain especially on October 17, 2014.

Petitioner filled out and submitted a Notice of Injury on October 27, 2014. Petitioner

testified he did not report his injury until seventeen days after the incident, because he "didn't really know the damage." (T, p. 13-14) The Commission finds Petitioner's testimony is not credible and contradicts his witnesses.

On his Notice of Injury, Petitioner reported Vince Bhatnager witnessed the incident. (Rx1) The Commission finds this fact was wholly fabricated. It is obvious Petitioner believed Vince Bhatnagar would corroborate his story. The Workers' Compensation coordinator emailed Bhatnagar on October 28, 2014, notifying him that he was named a witness. Bhatnagar responded ten minutes later "I did not witness Michael injuring himself. I don't believe I was in the office when the injury occurred. I can attest to Mike complaining about the injury the next day."

Bhatnagar filled out a Workers' Compensation Witness Report on October 28, 2014. He checked the box "no" in answer to "did you see the accident?" In answer to "date you witnessed" Bhatnagar wrote "10/13/14" and in response to "What did you see or hear?" Bhatnagar typed "Michael Martin was complaining about injuring his back due to having to move his desk in his office on the next work day after his injury. I was not in the office at the time the injury occurred." (Rx1) The form was signed by Bhatnagar and dated "10/28/14". It was established that "10/13/14" was a state holiday thus could not have been the date Bhatnagar heard Petitioner complaining about his back.

The Commission, therefore, infers Petitioner reported on the 27th Bhatnagar witnessed the accident, but did not realize Bhatnagar was not in the office at the time the injury occurred. Bhatnagar was never called to testify. The Commission finds Bhatnagar's witness report was contrived when Bhatnagar wrote it on the 28th and disregards this evidence.

Two months later, Petitioner's co-worker Al Hibbert authored a letter dated December 22, 2014. (Px3) Hibbert testified he gave the letter to Petitioner. (T, p. 37) Hibbert's letter states Petitioner told him on October 10, 2014, he "in his own words, felt a "pop" in his back while moving his desk, ..." The letter also states, "He reiterated his story to me and other people on break the following Monday morning of exactly what happened, and that his back had become increasingly painful over the weekend, to the point that he thought there might be something seriously wrong with it." Hibbert also testified that Petitioner was in obvious distress that Monday morning. Hibbert testified he socialized with Petitioner "a little bit" and they "kind of hit it off." Petitioner denied socializing with Hibbert.

Hibbert's letter is wholly contradictory to Petitioner's testimony that he never reported the injury until after he saw Dr. VanFleet because then, after his October 24th visit, he "finally realized" "that his pain was caused by moving the desk." Furthermore, the letter is wholly contradictory to Petitioner's own testimony that his pain started like a dull ache and Dr. VanFleet's history on October 24, 2014 of pain beginning one week prior on October 17th.

When informed on cross examination the following Monday, the 13th, was a state holiday, Hibbert conceded he could have been referring to Monday October 20, 2014 not Monday October 13, 2014. The Commission finds witness Al Hibbert's letter was written to corroborate Petitioner story on Petitioner's behalf and notes Hibbert was quite specific in the letter about Petitioner's appearance the following Monday. Given the following Monday was a state holiday, it is clear

Hibbert was confused about the dates, thus not a reliable witness and given his own perceived relationship to Petitioner, biased. He admitted he was "not exactly sure" that the initial conversation occurred on October 10th. (T, p. 40)

The supervisor's report of injury was signed by Teresa Woodcock. Petitioner testified Ms. Woodcock was his supervisor and they did not have a good relationship, she harassed him and with the union's assistance he was transferred to another supervisor. Petitioner was disciplined in part for abuse of his state computer including inappropriate internet use. (T, p. 27) He was suspended for three days effective January 3, 2014 through January 6, 2014. (Px7) The Commission disagrees with the Arbitrator's conclusion that the supervisor "was motivated to defeat the Petitioner's claim." (ArbDec, p. 6)

The Commission notes Petitioner's supervisor, Woodcock, did however, question the veracity of Petitioner's claim based upon the Supervisor's Report of Injury. Under "Description of Accident/Incident" she wrote: "not sure, Michael told me this morning (see above) he was filling out a work comp claim for an incident on October 17th. I asked him what for and he said moving his desk on that day (note: he was on vacation leave on October 17th from 1:00 p.m. to 4:45 pm). I told him he moved his desk on October 10th. He commented, 'whatever, it is what it is.'" (Rx1)

Under Description of Injury, Woodcock wrote: "not sure, he complained of his back and leg hurting him on October 20th. He left work on October 22nd at 9:00 am to see a chiropractor and was restricted from work until October 23. He came to work on October 24th with chiropractor's statement restricting him from work until October 27th - he was sent home. Michael came into my office this morning and stated he filled out a work comp claim for October 17th (see description of accident above)." (Rx1)

Petitioner's employment file contained some time records including State of Illinois "Staff Request for Time Off" records confirming Petitioner requested two hours and 15 minutes off on the alleged date of accident when he went for a medical appointment at Memorial Physician Services and paid cash for undocumented services. He was out of the office between 10:30 and 12:45. Petitioner was also approved for 3 hours and 45 minutes of vacation time on October 17, 2014, essentially Friday afternoon, between 1:00 and 4:45 p.m. corroborating his supervisor's email. (Rx5)

Respondent's workers' compensation coordinator Grace Simmons confirmed via email Petitioner reported his injury to her having occurred on Friday, October 17, 2014 which would comport with Hibbert's testimony that Petitioner was in distress on Monday October 20, 2014 and Woodcock's report that he complained of his back and leg hurting on October 20th. (Rx1) The Commission finds Petitioner failed to prove an accident occurred on October 10, 2014 based upon the totality of the evidence.

As a result of the Commission's findings herein, the Commission vacates the Arbitrator's Conclusions of Law in their entirely and reverses the Arbitrator's Decision regarding accident to find that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment with Respondent on October 10, 2014, rendering all other issues moot.

18IWCC0177

IT IS THEREFORE ORDERED BY THE COMMISSION the Arbitrator's Order awarding permanent partial disability is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION the Arbitrator's Order awarding medical services is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION the Petitioner has failed to prove by a preponderance of the evidence an accident arising out of and in the course of his employment and all benefits are hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that in light of the Commission's Decision regarding accident, all other issues are moot.

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, as the above claim is against State of Illinois, this Decision and Opinion on Review of the Commission is not subject to judicial review.

DATED: MAR 2 2 2018
KWL/bsd
O: 01/23/18
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Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTIN, MICHAEL
Employee/Petitioner

Case# **14WC038562**

STATE OF ILLINOIS DHS
Employer/Respondent

18IWCC0177

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:

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

JUN 26 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

Michael Martin
Employee/Petitioner

v.

State of Illinois, DHS
Employer/Respondent

Case # 14 WC 038562

Consolidated cases: _____

18IWCC0177

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **April 26, 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 **101/10/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$89,960.00**; the average weekly wage was **$1,730.00**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **2** dependent children.

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

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

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

ORDER

PETITIONER HAS SUFFERED 15% LOSS OF USE OF MAW AS A WHOLE FOR THE TOTAL AMOUNT OF 75 WEEKS AT RATE OF $735.37 PER §8(D)(2) OF THE ILLINOIS WORKER'S COMPENSATION ACT.

RESPONDENT SHALL PAY REASONABLE AND NECESSARY MEDICAL SERVICES, AS PROVIDED IN SECTIONS 8(A) AND 8.2 OF THE ACT AND PER THE STIPULATION OF THE PARTIES, SUBJECT TO ANY CREDIT PURSUANT TO SECTION 8(J).

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

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

D. Dylan McCarty

Signature of Arbitrator

6/21/2017
Date

JUN 26 2017

Findings of Fact

Petitioner is a 45 years old and has been employed with the State of Illinois, Respondent, since 2007. Petitioner current job is that of an Executive II for the Department of Human Services. His job entails dealing with contracts for vendors with the State. In 2014 Petitioner worked at DHS at the Federal Reporting as a statistical research specialist. (Trans. p. 8) The current claim is Petitioner's only workers' compensation claim he has ever filed. (Trans. p. 10)

Petitioner claims on October 10, 2014 he was working for the state of Illinois when he was requested to move his desk by his supervisor so she could have better viewing access to his work station. (Trans. p. 10) Petitioner identified Petitioner's Exhibit 2 for the record which confirms the events testified by Petitioner. (PX 2, Trans. P. 11)

Petitioner also identified Respondents Respondent's Exhibit 6 as the desk he was moving the day in question. (RX-6, Trans. P. 14) Petitioner described that on that date he was moving the desk he twisted his back and felt a pop and felt a dull ache but the pain progressed into a sharp pain and burning sensation with numbness going down his butt cheek and back leg. (Trans. p. 12-13)

Petitioner did not report his injury the day of the incident. Petitioner testified that he did not know the damage he did to his back. Petitioner did testify that he told a co-worker, Al, that he had hurt his back that day while moving his desk. Petitioner did not report his injury until October 27th of 2014.

Al Hibbert testified on behalf of the Petitioner in this claim. Mr. Hibbert works for the Harris Building department of Human Services for the past 36 years. (Trans. pg. 32-33) Mr. Hibbert testified he saw Petitioner in the afternoon on the date of the alleged accident holding his back and that Petitioner told him he'd hurt his back while moving his desk. Hibbert further said that on the date of the accident, the Petitioner appeared to be in pain. He said he observed him walking unusually, hunched over with a severe limp. Prior to that date, Mr. Hibbert never saw Petitioner favor his back. Mr. Hibbert identified Petitioner's Exhibit 3 as a letter dated, December 22nd, 2014 which he wrote on behalf of the Petitioner. The letter states that the Petitioner told him about the incident the day that it happened, and that the following work day, which he identified as Monday morning, the Petitioner appeared to be in pain and said that his pain had worsened over the weekend.

On cross examination, there appears to be some inconsistencies between Mr. Hibbert's testimony and his letter. He testified adamantly that he saw the Petitioner on the date of his alleged accident and he appeared to be in pain. His letter, written approximately two months after the accident, says that while the Petitioner told him he felt a pop in his back on the date he moved the desk, he appeared to be in pain early the next week, which he identified as the following Monday. Mr.

Hibbert admitted he may have been incorrect when he saw Petitioner after the injury as he acknowledged that the following Monday was a holiday, but reiterated that on the date of the injury he knew he saw Petitioner holding his back and tell him he had hurt it while moving his desk. (Trans. pg. 36-38)

Petitioner's Exhibit 1 was an employee notice of injury form filled out on October 27th 2014. Under the explanation on why the injury was not reported the day of the injury, Petitioner reported that the pain was bearable at first but over time it became intolerable. The document said that as he was pushing his desk when he felt a pop and tried to manage the pain but as time went on he became worse and pain started shooting down his left leg. It was at this point he sought medical treatment.

Respondent also offered exhibits dealing with whether an accident occurred as alleged. RX 1 contains a statement from a co-worker, Vince Bhatnagar. The statement was solicited by the Respondent's WC coordinator and appears to have been requested because the Petitioner said that Bhatnagar witnessed the accident. Bhatnagar's statement says that he did not see the accident, but that the Petitioner complained about his back hurting on the next work day after the injury. Bhatnagar's statement said the statement was made on October 13, which again was a holiday.

The same exhibit also contained a Supervisor's report of injury signed by Teresa Woodcock. The Petitioner testified that Ms. Woodcock was his supervisor and that they did not have a good relationship. He said that she constantly harassed him at work and that eventually, with his union's assistance, he was transferred to another supervisor. Ms. Woodcock's statement alleged that the Petitioner told her on October 27 that he was filling out a WC claim for an incident on October 17, which is when he said he was moving his desk. She told him he'd moved his desk on the 10th. There is also communication between Woodcock and Grace Simmons, another WC coordinator. In it Simmons also alleges that the Petitioner told her on October 27 that his injury occurred on the 17th.

The exhibit also contains a statement from an unidentifiable person alleging that the Petitioner was seen simulating his golf swing during his break during the period between October 20 and the 29th. The Petitioner testified that he was an avid golfer, and RX 2, a statement from the golf director at a local course, confirms that point. It should be noted however, that though the Petitioner had a scheduled tee time on October 24, 2014, he did not show up to the course to play.

Petitioner first sought treatment with Chatham Chiropractic. Petitioner testified he has seen this Chiropractor in the past and did regular adjustments. He could not recall the last time he saw the Chiropractor prior to this treatment. A patient history form was introduced as RX 3. It was dated

December 20, 2013 and it indicates that the Petitioner was being seen for lower back pain. The records from Chatham Chiropractic reflect that Petitioner first saw them after the accident on October 22, 2014 with complaints of an acute injury. Therapy for 2-4 weeks was recommended. Petitioner returned on October 23, 2014, with similar complaints and stated he wanted to pursue medical options. Respondent entered further records that show Petitioner treated with the Chiropractor earlier that year but not immediately prior to his accident. (RX 3)

Petitioner first sought treatment with Dr. VanFleet on October 24, 2014. In his intake he reported that he had hurt his back two weeks prior while moving furniture. He placed the episode of pain as one week prior. When stating how in injured himself Petitioner reported he was moving desk at work and notice slight pain but pain increased over time and now has pain shooting down back of left leg. The corresponding first date of treatment reflects the same mechanism of injury. Dr. VanFleet gave no work restrictions at that time and ordered physical therapy. Petitioner returned on November 21, 2014 after completing his physical therapy, at which time Dr. VanFleet ordered Petitioner undergo an MRI.

An MRI was performed on December 10, 2014. The MRI report reflects that Petitioner suffered a small protrusion at L5-S1 with abutment of the left S1 nerve root sleeve.

Petitioner followed up on December 12, 2014. At this point Dr. VanFleet recommended Petitioner undergo a L5-S1 micro discectomy. Petitioner underwent the micro discectomy on January 6, 2015.

On January 16, 2015 and February 11, 2015, Petitioner had post-surgical follow-ups. Petitioner was released on March 18, 2015 with no back pain and no bilateral leg pain. Petitioner testified at the time of his release he has some still dull aching pain from sitting and standing. But the shooting numbness and pain had resolved.

Since his release Petitioner has re-injured his back but did it at home and did not claim it as work related. Petitioner claimed he had reinjured his back while in the pool with his children. Petitioner claimed he had hurt the same part of his back as he had hurt in the injury in question.

Dr. VanFleet was deposed on October 5, 2016. He testified that he reviewed the December 10, 2014 MRI and found that Petitioner suffered an annual tear with abutment of the left SI nerve root. Dr. VanFleet agreed that type of tear could be traced to an acute injury (PX5 pg. 13) Dr. VanFleet reviewed two videos of Petitioner that were taken after the date of injury and found that neither video changed his opinion on the diagnosis. (PX5. Pg. 17, 18) Dr. VanFleet was given a hypothetical which was consistent to what Petitioner testified to at the time of trial including the delay in the onset of symptoms. After reviewing this hypothetical Dr. VanFleet opined that Petitioner injured his back when he was moving his desk at work which required surgical

intervention. (PX5 Pg. 19-20) Dr. VanFleet confirmed, on cross examination, that Petitioner could have experienced pain immediately or get worse over time. (PX5 24) Dr. VanFleet said that the Petitioner did not tell him about having any prior back pain. (Id at 24)

Conclusions of Law

In regard to disputed issues (C and D), the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner sustained an acute injury that arose in the course and scope of his employment to his back on October 10, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner provided emails from Petitioner's supervisor, Terry Woodcock, directly instructing him to move the desk and confirmation from the Petitioner that he did in fact move it the day in question on that date.

Petitioner also provided testimony of Al Hibbert, who confirmed that Petitioner was demonstrating pain behavior and told him that he had injured his back on October 10, 2014. Hibbert's insistence at trial that the Petitioner was clearly in pain on the date of accident does hurt his credibility. However, when considered with the other documented evidence, particularly the report of the second co-worker, Mr. Bhatnagar, the Arbitrator does give some weight to Hibbert's testimony. It is clear from Bhatnagar's statement that the Petitioner was complaining about his back on the first day back to work after the accident. The statement is consistent with Hibbert's letter, prepared much closer in time to the accident itself. More importantly, it is consistent with the Petitioner's testimony that his back pain initially was not severe but increased in severity as time went on. Dr. VanFleet's recorded history provides further corroboration to the Petitioner's testimony.

Ms. Woodcock's statement that the Petitioner reported an accident a week later than alleged is of little importance to the Arbitrator. It is clear from RX 1 that Ms. Woodcock was motivated to defeat the Petitioner's claim. The Petitioner's testimony concerning their relationship was unrebutted. Ms. Woodcock then sought out Grace Simmons to confirm that she was also given the wrong date of accident by the Petitioner. On December 19, 2014, Ms. Woodcock sent a letter to Respondent's WC attorney with documentation clearly aimed at assisting the claim's defense. She also included the fact that the Petitioner lifted a 25 pound pan on December 18th with the clear intent being to question whether he was actually injured.

The Arbitrator notes that Dr. VanFleet testified that a person with a herniated disc such as the Petitioner, confirmed by an MRI done on December 10, could both lift and carry a 25 pound pan and simulate a golf swing. (PX 5 at 17, 18)

The Arbitrator also is not bothered by the Petitioner's failure to tell the doctor about his lower back pain. At trial, he acknowledged the failure. He said he didn't mention the prior pain because his current paoin was much more severe. Dr. VanFleet was asked about the prior back treatment in his deposition and said that the failure of the Petitioner to report it did not change his opinions on causation. (PX 5 at 28) Finally, the record from the chiropractor were admitted into evidence as RX 3. The only reference to specific prior lower back problems was the intake sheet from December 23, 2013. It mentioned nothing about left leg radiation and contained no treatment notes.

While Petitioner did not report his injury until two weeks later, his testimony, supported by Dr. Vanfleet testimony, was credible that his injury developed slowly over time. Petitioner described an acute onset of injury to his chiropractor and gave a detailed and consistent explanation for his treatment with his intake with Dr. Vanfleet's office.

It is clear that the Petitioner had acute injury findings from October 22 forward. His testimony and history that the symptoms were not immediately severe was corroborated by what he reported to his co-workers and Dr. VanFleet.

Therefore, based upon the above the Arbitrator finds the Petitioner has shown by a preponderance of the evidence that he sustained an accidental injury arising out of his employment on October 10, 2014..

In regard to disputed issues (F and J), the Arbitrator makes the following conclusions of law:

Respondent offered no causation opinion at the time of trial. The only opinion given was that of Dr. Vanfleet who opined that the mechanism of injury described by Petitioner, moving a desk, was causally related to Petitioner's L5-S1 injury. Therefore having found in favor of the Petitioner on the issues of accident date and arising out of, The Arbitrator finds that Petitioner's treatment for said injury to be reasonable and necessary for injuries causally related to his accident, and awards medical bills in accordance with the stipulations of the parties. Respondent shall pay reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act and per the stipulation of the parties, subject to any credit pursuant to Section 8(j).

In regard to disputed issues (L), the Arbitrator makes the following conclusions of law:

Petitioner has suffered 15% loss of Man as a whole for the total amount of 75 weeks at rate of $735.37 per §8(d)(2) of the Illinois Worker's Compensation Act. The arbitrator bases this finding on the following:

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 an office worker. Per the Respondent's own job description, his job was mostly sedentary in nature. The Arbitrator notes that Petitioner testified he returned to his regular employment but that he suffered some discomfort and ache from long hours of sitting. *Some* weight was given 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 of his age Petitioner has a long career ahead of him to deal with his ongoing complaints and has already suffered re-injury to this part of his back due to a personal injury. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings' capacity, Petitioner returned to his employment full duty and was able to continue to perform it, this factor is given *Lesser* weight.

With regard to subsection (v) of §8.1b (b), evidence of disability corroborated by the treating medical records, Petitioner has continued pain complaints, of dull ache but resolution of his radicular complaints and personal complaints. Dr. VanFleet released the Petitioner with o restrictions on March 18, 2015. He said the Petitioner was doing well. He ordered him to do a home exercise program. (PX 5 at 16) His final therapy visit post surgery was on March 17, 2015. The Petitioner told his therapist that he'd played a round of golf the preceding Saturday and got along well swinging the club easier than normal. His examination showed some decreased hip flexion along with slight strength differences when compared to the right hip. This factor is given *greater* weight.

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

Christopher Parker,
Petitioner,

vs. NO: 16WC 12469

State of Illinois/Department of Transportation,
Respondent.

18IWCC0178

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 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 October 17, 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.

Pursuant to §19(f)(l) of the Act, as the above claim is against State of Illinois, this Decision and Opinion on Review of the Commission is not subject to judicial review.

DATED: MAR 22 2018
o032018
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PARKER, CHRISTOPHER
Employee/Petitioner

Case# **16WC012469**

SOI/IL DEPT OF TRANSPORTATION
Employer/Respondent

18IWCC0178

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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SPRINGFIELD, IL 62794-9208

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

18IWCC0178

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

CHRISTOPHER PARKER
Employee/Petitioner

Case # **16** WC **12469**

v.

Consolidated cases: _____

STATE OF ILLINOIS/DEPARTMENT OF TRANSPORTATION
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **April 12, 2017**. By stipulation, the parties agree:

On the date of accident, **March 28, 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 **$74,690.18**, and the average weekly wage was **$1,436.35**.

At the time of injury, Petitioner was **49** 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 **$all paid** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$all 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 $755.22/week for a further period of 75 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused 15% loss of use of the body as a whole.

Respondent shall pay Petitioner compensation that has accrued from September 13, 2016 through April 12, 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 16, 2017
Date

OCT 17 2017

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

18IWCC0178

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

CHRISTOPHER PARKER
Employee/Petitioner

v.

Case #: 16 WC 12469

STATE OF ILLINOIS/ILLINOIS DEPARTMENT OF TRANSPORTATION
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on March 28, 2016, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent, resulting in an injury to his right shoulder. The parties further stipulated that the only issue in dispute was the nature and extent of Petitoner's permanent partial disability.

On the date of accident Petitioner was 49 years old, married, and had two dependent children. He was employed as a Highway Maintainer. He testified that on that date he was lifting a drain culvert in order to put an end on it and he felt a pop in his right shoulder, followed by what he described as excruciating pain. Petitioner testified he had no prior workers' compensation claims, treatment, MRIs or surgery to his right shoulder. He is right-handed.

Petitioner was ultimately referred to Dr. Nathan Mall for pain in his shoulder which ran down into his arm. He testified that, "The bicep was hanging down to the base of my elbow...." He underwent surgery on his right shoulder, consisting of repair of the rotator cuff and reattachment of the bicep, which was torn completely loose. Following surgery, he participated in physical therapy with Dr. Baxter at Alternative Health Care, upon referral by Dr. Mall. He eventually returned to work in his normal position as a Highway Maintainer, which included performing mechanical repairs on equipment and trucks.

Petitioner testified that currently he is not as strong as he was before the accident and that he tires more easily. He uses over-the-counter pain medications a couple times a week and takes narcotic pain medication, left from his surgery, on rare occasions. He is able to perform his job duties but may not move as fast as he used to, which he attributed to the surgery and getting older. He is no longer able to shoot a gun without it causing excruciating pain and no longer able

to ride a 4-wheeler for very long, as it fatigues his shoulder and makes it sore. His range of motion is good and is equal to that of his left shoulder.

On cross-examination, Petitioner testified he was uncertain when he returned to work, but that it would have been whenever he was released to return. He was not sure if he had any restrictions when he first returned to work but did not believe he did, and he does not currently have any restrictions. He is no longer under the care of a doctor, though acknowledged he has continued under the care of Dr. Baxter for other conditions and has continued to receive chiropractic care for other issues. With regard to the narcotic medication he takes a couple times a month, he testified it was Percocet and that it was left over from his surgery. He takes the medication after long days of working, riding 4-wheelers, shooting guns or bows, lawn work, and similar activities which bring on the need for the medication. With regard to shooting a gun, Petitioner testified the problem is resting the gun on his shoulder, which causes pain. He does not have the same pain if he using a handgun. He is a shotgun and bow hunter, but was unable to do either this past year. Petitioner testified that any performance evaluations he has had since returning to work went satisfactorily and that there have been no issues at work to his knowledge. He confirmed he returned to work in the same position he held prior to the injury.

Following the accident on March 28, 2016, Petitioner presented to the emergency room at Massac Memorial Hospital. A shoulder x-ray revealed no dislocation or fracture. He was prescribed Norco, taken off work, and advised to follow up with his family physician. PX3.

On March 31, 2016, Petitioner presented to Dr. Thomas Staton at Baptist Health for both a general exam and his right shoulder injury. Dr. Staton ordered an MRI and suspected Petitioner had a rotator cuff tear. PX4.

On April 8, 2016, Petitioner presented to Dr. Nathan Mall at Regeneration Orthopedics and reported right shoulder pain. Dr. Mall noted he had previously seen Petitioner for problems with his *left* shoulder. Dr. Mall opined that Petitioner had a proximal bicep rupture, a high grade partial thickness rotator cuff tear, and AC joint arthrosis. He recommended surgery to consist of debridement of biceps stump, open biceps tenodesis, and possible rotator cuff repair of the subscapularis and supraspinatus. PX5.

On April 11, 2016, Petitioner underwent an MRI Arthrogram which revealed (1) anterior supraspinatus high grade partial thickness glenohumeral sided tear extending through 80-90% of the thickness of the cuff, along with intrasubstance tearing in the upper subscapularis; (2) torn biceps long head which was distally retracted to the humeral surgical neck level; (3) type II SLAP tear; (4) superior glenoid grade IV chondrosis; and (5) AC joint arthropathy resulting in mild supraspinatus myotendinous junction impingement and supraspinatus outlet stenosis. PX6.

On April 21, 2016, Petitioner underwent arthroscopic surgery by Dr. Mall, which consisted of (1) rotator cuff repair of the subscapularis, supraspinatus, and infraspinatus; (2) extensive debridement of the biceps stump, superior and anterior and posterior labrum; (3) extensive synovectomy of the glenohumeral space; (4) subcoracoid decompression and coracoplasty; (5) subacromial decompression and acromioplasty; (6) open AC joint resection;

and (7) open biceps tenodesis. At the end of the operative report, Dr. Mall noted that all of the injuries addressed in the surgery were causally connected to Petitioner's work accident. PX7.

Petitioner followed up with Dr. Mall on April 26, 2016, with minimal complaints. It was noted he was healing as expected and had been off pain medication for two days. Dr. Mall recommended starting physical therapy the following week. Petitioner returned to Dr. Mall on May 24, 2016, with minimal complaints. He was to continue physical therapy. He returned again on June 28, 2016, with minimal complaints. He was to continue therapy and gradually ease back into his with work with Respondent. Dr. Mall restricted his use of his right shoulder and advised he should not be doing any lifting with that arm. Petitioner followed up on July 26, 2016, and was advised to continue with therapy for six weeks, followed by two weeks of work conditioning if he believed he needed to increase his strength at that point. PX5.

Petitioner underwent physical therapy with chiropractor Angela Baxter from May 3, 2016, through September 13, 2016. Throughout his treatment he reported pain in his right shoulder, right arm, left and right trapezius, right triceps, cervical and thoracic and lumbar spine, and the sacroiliac region. He also reported migraines, tensions headaches, and problems with his vision. Petitioner advised Dr. Baxter that use of the joystick at work while on restricted duty caused irritation to his back, neck, and shoulder. It was noted in multiple visit notes that he was doing more than he should after surgery, which caused an increase in pain. Petitioner reported that these activities included working on his house, yard work, moving rock, running a tractor, cooking, and raking. He also reported he had moved and that he had lifted chairs, couches, and a tanning bed, all while using his right arm as little as possible. He informed his therapist that he had vacationed in Florida, causing him to miss two weeks of therapy and exercises, as he did not have his equipment with him during this time. PX10.

On September 13, 2016, Petitioner returned to Dr. Mall and reported he was "doing quite well" and had "minimal to no complaints". He advised he was back to doing all of his normal activities and believed he could return to work in a full-duty capacity. On examination, he had full active and passive range of motion and full strength in the supraspinatus, infraspinatus, and subscapularis. Dr. Mall noted, "The patient is doing amazingly well at this point." He released Petitioner to full duty work and placed him at maximum medical improvement. PX5. The Arbitrator notes this is the last record from Dr. Mall.

On November 30, 2016, Petitioner was evaluated by Dr. Michael Nogalski, Respondent's Section 12 examiner. Dr. Nogalski reviewed treating medical records, took a history from Petitioner, and performed a physical examination. He opined that Petitioner had pre-existing bicipital tendinopathic issues, subscapularis tendinopathy, and tendinopathy in the supraspinatus and infraspinatus areas. He further opined that Petitioner's work injury of March 28, 2016, might or could have aggravated his shoulder condition and caused the need for surgery, specifically with respect to his rotator cuff. He did not believe Petitioner sustained injury to his AC joint and that the related procedure was performed incidentally. Dr. Nogalski provided an impairment rating of 1%, pursuant to the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*. RX6.

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)**, Dr. Nogalski opined that Petitioner sustained an impairment of 1%, utilizing table 15-5 and subsequent pages relative to modifiers. He noted Petitioner was in Class 1 of rotator cuff injury, partial thickness tear with a history of painful injury and residual symptoms without consistent objective findings, Class B. He had a functional history modifier of Grade 1, physical exam modifier of Grade 0, and clinical studies modifier of Grade 0. The Arbitrator recognizes that impairment and permanent partial disability as defined by the AMA Guides are not the same, and the Arbitrator makes note of his distinction when assessing the weight given to Dr. Nogalski's impairment rating at issue and in determining the permanency award. The Arbitrator places significant weight on this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Highway Maintainer at the time of his accident and that he was able to return to work in that capacity without any restrictions or limitations as a result of said injury. Petitioner testified that he performs mechanical repairs on equipment and trucks on a daily basis and that he is not as strong as he used to be, which he notices when pulling on wrenches, pulling on pry bars, and the like. With regard to his job he testified, "Everything I do is physical with arms...." The Arbitrator notes the physical nature of Petitioner's job and places significant weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, the record reveals that Petitioner was 49 years old at the time of the accident. He has been able to return to his prior position without limitation and the Arbitrator notes he has several more years of working before reaching retirement age. Over time his condition could improve, stay the same, or get worse. There was no evidence to indicate with any degree of likelihood how his age would impact his disability, and the Arbitrator declines to speculate as to same. The Arbitrator gives some weight to this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner returned to his prior position full duty. There was no evidence that his future earning capacity has been or will be impacted as a result of his injury. As such, the Arbitrator places no weight on this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes that Petitioner sustained an injury to his left shoulder. He underwent surgery consisting of rotator cuff repair of the subscapularis, supraspinatus, and infraspinatus; extensive debridement of the biceps stump, superior and anterior and posterior labrum; extensive synovectomy of the glenohumeral space; subcoracoid decompression and

coracoplasty; subacromial decompression and acromioplasty; open AC joint resection; and open biceps tenodesis. Petitioner testified that he currently feels his right dominant arm is not as strong as it used to, which he notices particularly when using wrenches and pry bars at work. He testified he is sore at the end of nearly every shift. He takes over the counter pain medication, uses ice, and rarely uses narcotic pain medication. Petitioner's testimony is partially corroborated by Dr. Mall's records, which noted recovery was normal and what the doctor expected. His testimony is not necessarily corroborated by Dr. Baxter's physical therapy records, which note that he overexerted himself around his home by moving large heavy pieces of furniture, ran tractors, and did work in and around his home. He reported on several occasions that he was "overdoing it" in his spare time off work, causing pain and discomfort. Dr. Mall's note following Petitioner's final visit of September 13, 2016, indicated Petitioner had minimal to no complaints, was "doing amazingly well", had full range of motion and full strength, and was able to work full duty. 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 15% loss of use of the person as a whole (75 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitoner's average weekly wage was $1,436.35. The Arbitrator finds that his permanent partial disability rate is $755.22, the statutory maximum rate applicable to his date of accident.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

VICTOR BAKER,

Petitioner,

vs.

NO: 16 WC 34183

ZF LEMFORDER,

Respondent.

18IWCC0179

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, prospective medical care, temporary total disability and §19(L) penalties, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner worked as an Assembler for Respondent. He assembled various parts onto frame chassis, which is the bottom of the car.

18IWCC0179

2. On November 6, 2016 Petitioner was working his shift when suddenly there was a loud crash behind him. He then felt a rack hit him in the back and knock him onto the assembly line he was working on. The rack held crates, some of which held heavy duty car parts. A forklift driver had crashed the forklift into the rack, which then was pushed into Petitioner.

3. Subsequently, Petitioner reported the accident to his supervisor and complained of back, chest, shoulder and neck pain. He also provided a written account of the accident.

4. Petitioner was sent to the emergency room, where he underwent x-rays and was diagnosed with a back strain and contusion. He was also prescribed pain medication.

5. The following day, Petitioner visited Respondent's physician, and was told to undergo physical therapy so that he could return to work that afternoon. However, that afternoon Petitioner underwent an MRI, was diagnosed with sciatica and a degenerative disc. Additionally, cervical and lumbar injections and surgery were discussed.

6. At trial, Petitioner's pain was a 7/10 in his upper and lower back and legs. He also complained of shooting pains down his legs. Per doctor's orders, he has been unable to return to work.

The Commission affirms the Arbitrator's rulings on accident, causal connection, medical expenses, prospective medical care and temporary total disability. However, the Commission modifies the Arbitrator's award of §19(L) penalties. The Commission views the evidence slightly different, and finds that penalties should only be assessed through the initial pre-trial hearing date of February 9, 2017.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner §19(L) penalties of $30.00 per day for 95 days, a total of $2,850.00.

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

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

18IWCC0179

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $29,000.00. 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.

MAR 22 2018

DATED:
O: 1/25/18
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

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

BAKER, VICTOR
Employee/Petitioner

Case# **16WC034183**

ZF LEMFORDER
Employer/Respondent

18IWCC0179

On 5/31/2017, 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 1.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN AND MACIARIELLO
KATLYN ROWE
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

2965 KEEFE CAMPBELL & ASSOC LLC
SHAWN R BIERY
118 N CLINTON ST SUITE 300
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)
- [x] None of the above

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

Victor Baker
Employee/Petitioner
v.
ZF Lemforder
Employer/Respondent

Case # 16 WC 034183

18IWCC0179

An *Application for Adjustment 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 **April 12, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0179

FINDINGS

On the date of accident, **11/6/2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$31,200.00**; the average weekly wage was **$600.00**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **5** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner **temporary total disability benefits of $400.00 per week for 22-3/7 weeks, commencing November 7, 2016 through April 12, 2017, as provided in Section 8(b) of the Act.**

Respondent shall pay **reasonable and necessary medical services of $15,179.41, as provided in Sections 8(a) and 8.2 of the Act.**

Respondent shall authorize and pay for the cervical and lumbar ESI injections offered Petitioner by Dr. Agrawal and all related services, in accordance with §§8(a) and 8.2 of the Act.

Respondent shall pay to Petitioner **penalties** of **$0**, as provided in Section 16 of the Act; **$0**, as provided in Section 19(k) of the Act; and **$4,710.00**, as provided in **Section 19(l) of the Act.**

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

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

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

Signature of Arbitrator

May 31, 2017
Date

MAY 31 2017

18IWCC0179

STATEMENT OF FACTS

Petitioner was employed by Respondent as an assembler, working the C Shift (6:00pm to 6:00am). He had been so employed for one year and one month. As an assembler, Petitioner would put parts on car chassis. He would rotate to various operations, handling parts weighing from 3 to 15 pounds, performing 600 assemblies a shift. Most of Petitioner's work is done at waist level while standing at the assembly line.

Petitioner testified that he was injured while working on November 6, 2016. He felt fine that day before the accident. A fellow employee crashed a forklift into a rack that was behind Petitioner. Petitioner was facing away from the rack and facing towards the assembly line. Petitioner testified that the rack hit him in the back and pushed him into the line. His chest hit the line. Petitioner said that he did not feel sensations at that time. He was "shocked" and felt adrenaline from the event. He tried to pick up some parts that had fallen off the rack. His co-employee did not see the accident. There were no lead employees present.

About 5 to 10 minutes later, Petitioner noticed that his back, chest, shoulder and neck were hurting. On cross-examination, Petitioner said that it was not a specific shoulder that was hurting, but it was his back, between the shoulders. He informed his supervisor and was taken off line. Respondent sent Petitioner to Franciscan Health Emergency Department in Hammond, Indiana, via taxi.

At Franciscan, Petitioner complained of mid and low back pain after being struck by objects. The patient said that he was struck in the lower thoracic and proximal lumbar spine. He had back pain and tingling in his left leg. The physical exam revealed that the neck was non-tender, with normal range of motion. Diffuse tenderness to palpation in the thoracic and lumbar spine was noted. No redness, bruising or abrasion was noted. The thoracic spine x-ray was negative. Minimal degenerative spondylosis was noted at L3-L4. No c-spine x-ray was done. The x-rays showed no acute pathology. The diagnosis was: acute bilateral low back pain without sciatica and acute mid-back pain. Petitioner was discharged and instructed to follow-up with his PCP, ASAP (within 2 days). (RX 3)

While Petitioner testified that he was told he had a back strain and a concussion on Direct, on Cross, he agreed that he was told he had contusions. Petitioner testified that he went back to work after being released from Franciscan.

The next day, November 7, 2016, Respondent sent Petitioner to Concentra in Hammond. The history was that a forklift hit a rack, the rack hit the patient and the patient fell on a chassis. Petitioner complained of pain from his neck down to his low back. He denied numbness or weakness of the left leg, but did admit to tingling. He gave a history of a prior back injury, 8 years before, with a herniated disc and an ESI. Since then, he has had stiffness, but no back pain. The physical exam showed a completely benign cervical spine exam (normal lordosis, no tenderness, full range of motion). The T-spine exam showed tenderness at the right and left rhomboid, no spasm and full range of motion. The lumbar spine exam showed tenderness to palpation, left and right, no spasm, full range of motion, left flexion painful, negative SLR, neuro-sensation was intact, reflexes were not mentioned. There was no evidence of trauma noted. Petitioner was prescribed Naproxen and PT. He was released to return to work at modified duty (lift 25# occasionally, pull/push 30# occasionally, limit bending) and was told to follow up in 2 days. The diagnosis was: Strain of muscle & tendon of unspecified wall of thorax; radiculopathy-

lumbar region; strain of muscle fascia and tendon of lower back; thoracic spine. Petitioner was discharged at 9:45am. (RX 4)

Petitioner did not contact Respondent about returning to work. Instead, he signed the Application for Adjustment of Claim at 10:29 CST. (PX 1)

Petitioner then presented for treatment to AMCI-South Holland Medical Center on November 7, 2016. Unfortunately, the time that he was seen is not documented, although Petitioner testified that it was "that afternoon". Petitioner was seen by Dale Hooten, DC, with a history of a work injury: a fellow employee hit a set of racks with a forklift, the racks were pushed into the back of Mr. Baker, causing him to fall on the chassis that he was working on. Petitioner complained of 8/10 neck pain, increased with bending and turning of his head; mid-back and low back pain was an 8, increased with sitting, rising, standing, bending and lifting. "He has been experiencing pain in his posterior left thigh and numbness and tingling in the lateral edge and bottom of his left foot. He has had a difficult time performing daily activities since the accident. Sleeping has been difficult due to pain." He had no previous accidents or trauma to the area of chief complaints. The physical exam revealed dramatically more subjective complaints than that noted at Franciscan or Concentra, regarding the C-spine, T-spine and Lumbar spine. Reflexes, motor and sensory exams were normal. There was no documentation of any evidence of trauma. The diagnosis was: Cervical sprain; Thoracic sprain; Lumbar sprain; and Lumbar radiculitis. The "diagnoses are causally related to the incident noted in the history above." Petitioner was taken off work, prescribed medications, instructed regarding posture, activity limitation, moist heat and HEP. PT was to be considered. (PX 2)

Respondent had an investigation regarding the accident and prepared 2 reports regarding interviews with co-employees. The reports were tendered as Respondent's Exhibit 1 and were admitted only as to the issue of penalties. The reports are hearsay and are not considered for the truth of the matter asserted. Respondent did not submit the testimony of the co-employees, or of any other occurrence or non-occurrence witnesses, so Petitioner's testimony stands unrebutted.

Petitioner has continued on a course of treatment with AMCI from Dr. Michael Foreman, MD, Dr. Hooton, DC, Dr. Daliege, DC, Dr. Divya Agrawal, MD, including therapy, massage, opiates, Cervical and Lumbar MRI studies, EMG/NCV and an FCE. At some point, Petitioner developed left lower extremity weakness, which led to a fall and a hand laceration. The chart of November 16, 2016 says that the LLE weakness was present since the date of accident, which is not correct. Dr. Agrawal recommends cervical and lumbar ESI injections. Without the injections, Petitioner may be at MMI. The last treatment at AMCI was on February 14, 2017. The current diagnosis is: Cervical sprain; Thoracic sprain; Lumbar sprain; Lumbar radiculitis; Right hand sprain; Cervical herniated disc; Cervical stenosis; Lumbosacral herniated disc; Lumbar stenosis; Cervical radiculitis. The physicians at AMCI causally relate these conditions to the injury. Petitioner is continued to be excused from work. (PX 2)

Dr. Foreman interpreted the C-spine and Lumbar spine MRI's as showing disc protrusions, nerve effacement and stenosis. The EMG/NCV study of the C-spine was negative. The L-spine EMG/NCV was said to show left more than right L5-S1 radiculopathy. The FCE, done on 1/3/2017, places Petitioner at light duty, lifting 20# occasionally, 10# frequently and 4# constantly. (PX 2)

Petitioner wants to undergo the recommended ESI procedures. He has pain in his back and shoulders. He has pain in his low back and legs. On a bad day, his pain is a 9. On a good day, his pain is a 5. He has numbness and tingling. He thinks that the cause of his complaints is the injury. He does not think

that he is physically able to return to work. He could do his job before the accident. He is taking Gabapentin, Tramadol and Flexerill. He has not been paid any benefits. This is causing a financial hardship. Petitioner testified on Direct that he had no prior low back pain or complaints and no prior neck or shoulder complaints or pain. On Cross, Petitioner admitted to prior back problems, including a prior diagnosis of a herniated disc. On Re-Direct, Petitioner said that his back was asymptomatic before the accident and afterwards, he had pain.

Neither Petitioner nor Respondent followed up regarding the FCE and possible return to work at light duty. Respondent did not obtain an IME and did not submit any of the bills to UR.

Petitioner filed a Petition for Penalties (PX 5) and Respondent filed a Response (RX 5). Respondent submitted no evidence of its compliance with Rule 9110.70.

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 her injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989) To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 205 (2003) 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 (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on November 6, 2016, based upon the evidence adduced.

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

The Arbitrator finds that Petitioner's current condition of ill-being regarding his cervical spine, thoracic spine and lumbar spine are causally related to the injury, based upon the evidence adduced.

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 medical services that were provided to Petitioner were reasonable and necessary and causally related to the injury, based upon the evidence adduced.

At trial, the following unpaid medical bills were submitted by Petitioner and are awarded, pursuant to §§8(a) and 8.2 of the Act:

AMCI: Associated Medical Centers of Illinois	$9,981.00
EQMD:	$3,247.91
Franciscan Alliance:	$1,950.50
	Total: $15,179.41

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

The Arbitrator finds that Petitioner is entitled to prospective medical care, to wit: the proposed cervical spine and lumbar spine ESI procedures offered by Dr. Agrawal, based upon the evidence adduced. Respondent is ordered to authorize and pay for same and all related services, pursuant to §§8(a) and 8.2 of the Act.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner is entitled to TTD benefits commencing November 7, 2016 through April 12, 2017 (22-37 weeks) based upon the evidence adduced.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Given the Arbitrator's findings regarding the above issues and Respondent's failure to show compliance with Rule 9110.70, the Arbitrator finds that Petitioner is entitled to §19(l) penalties. The award for §19(l) penalties is $30.00 per day for 157 days, or $4,710.00.

Considering the evidence adduced and Respondent's Exhibit 1 for its limited purposes, the Arbitrator declines to award §19(k) penalties or §16 attorney's fees.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EDWARD TORREZ,

Petitioner,

vs. NO: 10 WC 41701

MINUTE MEN STAFFING SERVICES,

Respondent.

18IWCC0180

DECISION AND OPINION ON §19H/§8A PETITION

A §19H/8A Petition having been filed by Petitioner's attorney herein and due notice given, this cause came before Commissioner Gore on October 23, 2012, November 10, 2015, May 3, 2016, November 1, 2016 and November 15, 2016. The Commission having jurisdiction over the persons and subject matter, and after being advised in the premise, finds:

1. Petitioner was a Crane Operator who suffered a work-related accident to his left foot on April 21, 2010. Petitioner eventually underwent an open reduction and internal fixation of the medial malleolus and insertion of a syndesmotic screw. The operating surgeon opined that it was more likely than not that Petitioner would later develop post-traumatic arthritis, but that, for now, Petitioner was able to work full duty with no restrictions. On April 19, 2011 the Arbitrator filed a Decision finding causation and awarded permanent partial disability (PPD) benefits due to a 45% loss of use of Petitioner's left foot under §8(e) of the Act.

2. In November 2011 Petitioner moved to Texas and was hired at an automobile assembly plant. As predicted by the surgeon, he developed arthritis, which cut his employment short at his new job after 2 months.

3. Petitioner treated with Dr. Nilsson on May 4, 2012 for his ankle pain, which he stated was progressively getting worse, along with increased swelling. Petitioner was referred to an ankle specialist to discuss ankle replacement and fusion.

4. On June 5, 2012 the ankle specialist, Dr. Casillas, recommended left ankle replacement and restricted Petitioner to desk work until after the surgery.

5. Petitioner's job on the assembly line in Texas required a lot of walking. Soon, his foot began to swell to the point where it was difficult to put on his work boot. When Petitioner left this employment he attempted to work elsewhere, but was unable to pass the physical.

6. On July 25, 2012, Petitioner filed a §19(h)/§8(a) Petition.

7. The day after the October 23, 2012 hearing, Respondent had Petitioner examined by Dr. Suchy, who opined that Petitioner had developed post-traumatic degenerative joint disease of the left ankle. Dr. Suchy anticipated that further surgical intervention would be necessary, and that Petitioner would suffer some permanent loss of motion and permanent restrictions due to this.

8. Petitioner underwent ankle replacement surgery with Dr. Casillas on February 6, 2013. After therapy, he was released to sedentary desk duty on August 20, 2013.

9. On February 18, 2014 Dr. Casillas recommended work hardening and placed Petitioner on restricted duty with no lifting over 20 pounds and limited standing, walking and climbing.

10. Petitioner received a job offer from Respondent in November 2013, shortly before Thanksgiving. After the holiday, Petitioner learned that the offer had been rescinded. Respondent then offered another light duty position to Petitioner, which began on March 12, 2014 in Illinois.

11. Petitioner underwent work hardening while simultaneously starting his new job, thus he was not working full time. He received temporary partial disability (TPD) benefits in lieu of full pay.

12. After work hardening, Petitioner underwent a functional capacity evaluation (FCE) on April 23, 2014. The FCE revealed that Petitioner could work at a heavy physical demand level.

13. Petitioner indicated that after work hardening, his left ankle felt stronger and more stable.

14. Despite the FCE results, on May 27, 2014 Dr. Suchy placed Petitioner on permanent restrictions of no excessive walking, no lifting over forty pounds, and no ladder-climbing. This precluded Petitioner from returning to work for Respondent as a Crane Operator, as he could not climb the ladder to get into a Crane. Dr. Suchy stressed the importance of avoiding excessive walking due to Petitioner's young age and the wear and tear it could cause on the prosthesis.

15. Respondent accommodated the restrictions, as Petitioner now works as a sit-down Security Guard at Party City Warehouse. He sits 80% of the time, but still experiences pain and

discomfort sitting for extended periods, walking for any length of time or exercising too long on an elliptical (part of his ordered weight loss program, which will help prolong the life of his prosthetic).

The Commission grants Petitioner's §19(h)/§8(a) Petition. While Petitioner indicated that his pain had subsided by May 2014, and his ankle felt stable, the Commission also takes into consideration that Petitioner has undergone ankle replacement surgery since the previous adjudication of this case. Although his condition has improved subsequent to surgery, Petitioner still suffers from residual symptoms if he sits, walks or exercises too much. Accordingly, the Commission grants the §19(h)/§8(a) Petition, as it finds a material increase in Petitioner's disability, and awards him an additional 25% loss of use of his left foot.

In addition to the additional PPD award, Petitioner is entitled to additional reasonable and necessary medical expenses. Dr. Scales' interpretation of the Official Disability Guideline led him to the conclusion that the 29 work hardening sessions Petitioner underwent between March 12, 2014 and April 22, 2014 were not reasonable or necessary, as Petitioner was more than 2 years removed from injury, and thus did not qualify for work hardening. However, on Cross Examination, Dr. Scales admitted that he did not blindly follow the Official Disability Guideline and treated patients on a case by case basis. He also admitted to not having reviewed any of Petitioner's medical records prior to work hardening, thus he was in no position to ascertain Petitioner's physical condition and need for treatment leading up to work hardening. He admitted that a surgery subsequent to an accident could alter the timeline for qualification for work hardening. A total ankle arthroplasty lends itself to an altered recovery and treatment timeline. Furthermore, work hardening began thirteen months after the surgery, which is well within the 2-year timeline set out by Dr. Scales.

Petitioner stipulated that no TTD was being sought, and accordingly Respondent stipulated that it was not seeking credit for TTD paid.

Lastly, the Commission denies Petitioner's request for Penalties and Fees. At minimum, Respondent had legitimate cause to question the validity of the medical bills submitted by Petitioner. The Apria Healthcare (Wheelchair) and PSI Premier Specialties (Walker) bills were brought to Respondent's attention on November 10, 2015. However, an April 2014 FCE report indicated that Petitioner was capable of full/heavy duty work. It was reasonable for Respondent to surmise that a person released to heavy duty work would not be in need of a wheelchair and/or walker. Additionally, the ATI Physical Therapy bills were brought to Respondent's attention in May 2016. In August 2016 Dr. Scales reviewed the work hardening treatment and opined that Petitioner was not even qualified to undergo work hardening. Accordingly, Respondent had adequate, though ultimately unreliable medical information with which to base its' decision to refuse payment on. Accordingly, the Commission denies Petitioner's request for penalties and fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's §19(h)/§8(a) Petition be granted.

18IWCC0180

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for all reasonable and necessary additional medical expenses related to Petitioner's ankle replacement surgery.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to an additional PPD award of a 25% loss of use of his left foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Penalties and Fees Petition be denied.

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

DATED: MAR 22 2018
DLG/wde
O: 10/12/17
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TORREZ, EDWARD
Employee/Petitioner

Case# **10WC041701**

MINUTE MEN STAFFING SERVICES
Employer/Respondent

18IWCC0180

On 8/19/2011, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0412 JAMES M RIDGE & ASSOC
AMYLEE HAGAN SIMONOVICH
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

0075 POWER & CRONIN LTD
JEFFREY B HUEBSCIT
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

EDWARD TORREZ,
Employee/Petitioner

Case # 10 WC 41701

v.

Consolidated cases: None

MINUTE MEN STAFFING, SERVICES,
Employer/Respondent

18IWCC0180

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Ottawa**, on **June 24, 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. ☐ Did an accident occur that arose out of and in the course of 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 21, 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 **$36,437.44**; the average weekly wage was **$700.72**.

On the date of accident, Petitioner was **39** 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 **$4,072.88** for TTD, **$793.61** for TPD, **$0.00** for maintenance, and **$3,546.35** for other benefits, for a total credit of **$8,412.84**.

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

ORDER

Respondent shall pay petitioner temporary total disability benefits of **$467.15**/week for **8-4/7** weeks, commencing **April 22, 2010** through **June 20, 2010**, as provided in Section 8(b) of the Act.

Respondent shall pay petitioner temporary partial disability benefits of **$34.08**/week for **23-2/7** weeks, commencing **June 21, 2010** through **December 1, 2010**, as provided in Section 8(b) of the Act.

Respondent shall pay petitioner permanent partial disability benefits of **$420.43**/week for **75.15** weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to his **left foot** to the extent of **45%** thereof.

Respondent shall pay the petitioner compensation that has accrued from **April 21, 2010** through **June 24, 2010**, 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 **JOANN M. FRATIANNI**

August 12, 2011
Date

AUG 19 2011

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

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

Petitioner is employed with Respondent as a crane operator and was assigned to work at Illini Pre-Cast. On April 21, 2010, Petitioner was uncovering poured concrete when he fell in a hole and fractured his left ankle.

Petitioner was initially treated at Tyler Medical clinic where he came under the care of Dr. Suchy. Dr. Suchy diagnosed a left ankle tri-malleolar fracture/dislocation and prescribed surgery. (Px1) On April 24, 2010, Petitioner underwent surgery with Dr. Suchy in the form of an open reduction and internal fixation of intra-articular fracture of he left distal tibia and fibula, pylon open reduction and internal fixation of the medial malleolus and insertion of syndesmotic screw. (Px3) Post surgery, Petitioner was prescribed physical therapy and remained under the care of Dr. Suchy.

Petitioner returned to work on June 21, 2010 ambulating with crutches and requiring assistance to get in and out of his crane. Dr. Suchy released him to return to full duty work on September 10, 2010.

On November 29, 2010, Dr. Suchy surgically removed a portion of a broken screw with a portion still remaining in the bone. Petitioner following that surgery was prescribed physical therapy and was released to light duty work on December 10, 2010, and full duty work on January 18, 2011. Dr. Suchy released Petitioner from all medical care on April 14, 2011. Dr. Suchy indicated that it was more likely than not Petitioner will develop post traumatic arthritis and noted that he is performing his regular work duties without significant medical restrictions. (Px3, Rx4)

Petitioner testified that he is unable to walk barefoot and no longer runs, and experiences difficulty when bending his foot. Petitioner has difficulty walking over uneven ground and assisting workers with tasks on the ground. Petitioner experiences a sharp pain when walking on uneven ground and notices that it aches and tires after two hours of standing and walking. Petitioner further testified that he now walks with a limp and the left foot is sensitive to weather changes.

Petitioner testified that he did not experience any injuries to his left foot or ankle before this accident or after this accident.

Based upon the above, the Arbitrator finds that the conditions of ill-being as noted above are causally related to the accidental injury of April 21, 2010, and that these conditions are now permanent in nature.

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

Martha Castellanos,

Petitioner,

vs. NO: 15WC 23315

Greif Containers,

18IWCC0181

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 16, 2017, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 23 2018
o032018
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

CASTELLANOS, MARTHA
Employee/Petitioner

Case# **15WC023315**

GREIF CONTAINERS
Employer/Respondent

18IWCC0181

On 5/16/2017, 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 1.02% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0307 ELFENBAUM EVERS & AMARILIO
RACHAEL J SINNEN
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

0532 HOLECEK & ASSOCIATES
JEFF GOLDBERG
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

18IWCC0181

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)

Martha Castellanos
Employee/Petitioner

v.

Greif Containers
Employer/Respondent

Case # 15 WC 23315

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 **December 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **6/19/2015**, 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* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$57,954.52**; the average weekly wage was **$1,114.51**.

On the date of accident, Petitioner was **51** 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 is entitled to a credit of **$23,564.03** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$50,986.87** for other benefits, for a total credit of **$74,550.90**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$743.01**/week for **69-5/7** weeks, commencing **6/24/2015** through **11/30/2015**, from **12/10/2015** through **2/11/2016** and from **3/31/2016** through **12/19/2016**, in accordance with Section 8(b) of the Act. Respondent shall be given a credit of **$23,564.03** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner **$67,745.23**, which is an amount equal to the charges for the reasonable and necessary medical services rendered to her, less **$50,986.87** for medical benefits that have been paid, as provided in Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall authorize and pay for the left shoulder surgery that Dr. Sompalli has recommended, and shall authorize and pay for the cervical injections that Dr. Chunduri has prescribed.

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

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

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

Signature of Arbitrator

May 16, 2017
Date

ICArbDec19(b)

MAY 16 2017

State of Illinois)
)
County of Cook)

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION

Martha Castellanos,	)	
	)	
Petitioner,	)	**Setting: Chicago**
	)	
v.	)	**Arb. Brian T. Cronin**
	)	
Greif Containers,	)	**IWCC No. 15WC 23315**
	)	
Respondent.	)	

Hearing under Section 19(b)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

FINDINGS OF FACT

1. **Petitioner's work history and job duties**

The Petitioner, Martha Castellanos, testified in Spanish through an interpreter. Petitioner testified that she had worked for the past 14 years as a machine operator at Greif Containers, a business that makes steel drums. On June 19, 2015, the date of accident, her position was that of Helium Tester. Her job duties included testing 55-gallon drums on a production line. The job description states that the position requires repetitive movement of the arms, wrists and hands, and an ability to lift "up to 50 pounds (approximately 33% of time)." (Petitioner's Exhibit "Px" 9) Petitioner testified that the job description had been translated for her. She agreed that it was accurate and complete, but did not include her duty to place covers on drums.

Petitioner testified that she had no prior injuries to her low back, neck or left shoulder, and that she had no prior workers' compensation claims. As of June 19, 2015, she had no injuries and was not under any work restrictions.

2. **Date of accident: June 19, 2015**

Petitioner testified that on the morning on June 19, 2015, at approximately 11:30, she went to check on her machine and saw that a drum had fallen onto Chamber No. 1. She locked the machine and walked to the main door. She tried to open the door but it was impossible because there were so many drums leaning against it. She approached the conveyor, went in and picked up the drum. As she was lifting the drum and taking a step backwards, an "L-shaped" piece of steel struck her

in her back. The piece of steel hit her "close to [her] lung." Petitioner demonstrated that the piece of steel struck her in her mid-back. She felt a sensation "like a fire" come into her body. She felt pain everywhere. When asked to be more specific, she further testified that she felt pain in her back, neck and left shoulder. She testified that the piece of steel was a couple feet long, about 4-5 inches wide. It struck her in the back, "towards [her] neck and towards [her] shoulder."

On cross-examination, Petitioner testified that the item she was trying to dislodge at the time of the accident was a 55-gallon drum. She had to totally move it back onto the conveyor. She was focusing on grabbing the drum at the time. She bent over. When she grabbed the drum, the piece of metal struck her. This piece of metal was a couple of feet long and the width of her hand. She did not fall down when the piece of metal struck her. The piece of metal did not hit her in the head.

Petitioner further testified that her co-worker, Guadalupe Galvez, saw the accident and came over to help her. Petitioner's supervisor, Robert, passed by shortly afterwards, and Ms. Galvez informed him of Petitioner's accident. Robert took Petitioner to the office and gave her pills and an ice pack, which she applied to her back for about twenty minutes. Petitioner testified that she finished working the remainder of her shift, which was about two hours. She did all the work that she was supposed to do. She left work when her shift ended. That night, her pain intensified.

The next day was Saturday and Petitioner was not scheduled to work. She testified that on Monday morning, June 22, 2015, she called her employer and reported that she was in pain. She was told by her superintendent to go to the company clinic.

3. **Initial treatment by Respondent's company clinic and Petitioner's family doctor**

Petitioner testified she went to the Ingalls company clinic for treatment on June 22, 2015. Petitioner testified that the clinic doctor did not speak Spanish but she was able to communicate because she speaks a little English. She told him that her neck and left arm were in pain.

The June 22, 2015 records of Ingalls Occupational Health reflect a Chief Complaint of "Neck Strain," and a PATIENT DESCRIPTION OF ACCIDENT as follows: "Patient states while picking up a drum to put into chamber and felt a pinch in neck (sic)." (Px 4, p. 2) The "HISTORY OF PRESENT ILLNESS" is as follows: "Martha's primary problem is pain located in the neck. She describes it as aching to sharp. She considers it to be moderate. Martha says it seems to be constant. She has noticed that it is made worse by exertion. It is improved with rest. She feels it is not improving. Her pain level is 6/10. No previous injury to body part." (Px 4, p. 2)

Upon examining Petitioner, Raza Akbar, M.D., found, with regard to her neck, no abrasion, no bruising, no erythema and no open wound. He did find pain to palpation along the mid-cervical paraspinals, and a general decreased range of motion, especially right rotation, and tenderness to palpation over the left trapezius insertion posteriorly. (*Id.*, p. 3)

With regard to her left shoulder, he found decreased flexion and abduction due to left shoulder pain, pain over the AC joint and posterior upper scapula, reproduction of posterior scapular pain with shoulder movements, and pain with resisted deltoid. (*Id.*, p. 3)

X-rays of the cervical spine and scapula revealed no acute findings. (*Id.*, p. 3)

Dr. Akbar diagnosed "cervical strain/sprain" and "left shoulder pain—rule out radiculopathy." He prescribed Ibuprofen and application of heat and placed Petitioner on restricted duty. (*Id.*)

Petitioner testified that she returned to work with restrictions the following day, but only for one day. Her hand began to swell and she was in pain. She asked her supervisor to send her back to the company clinic, but she had to wait and use the ice pack he provided. Petitioner testified that she was able to finish her shift, but was in a lot of pain.

After work that day, June 23, 2015, she consulted Carlos Garavito, D.C., of Midwest Medicorp, on the advice of Elizabeth Becerra, M.D., her family doctor. She gave a history of a June 19th accident in which she was struck by a tube in the left shoulder and mid-back area while lifting a drum at work. (Px 3, p. 7) Dr. Garavito, a chiropractor, noted complaints of low back, neck, left shoulder and left shoulder blade pain, with difficulty using the left arm. (*Id.*) He recommended chiropractic physical therapy and a follow-up visit to Dr. Becerra. (*Id.*, p. 9)

Petitioner testified that she saw Dr. Becerra the next day. Dr. Becerra recorded a history of injury virtually identical to that noted by Dr. Garavito. Petitioner reported "pain on her left upper back and goes down to her left hand on and off. Arm feels tired when trying to do normal activities." (Px 5, p. 35) Upon examination, Dr. Becerra found, *inter alia*, tender cervical muscles, left more than right, a mild bruise over the medial aspect of the left scapula with muscle spasm and tenderness, tender on arm ROM, decreased hand grip on left hand and left arm strength 4/5 vs. right arm strength 5/5. Dr. Becerra prescribed steroids, along with continued physical therapy and work restrictions. (*Id.*, pp. 35-36)

Petitioner testified that she did not go back to work. She began receiving TTD benefits and workers' compensation approved her therapy. Initially, Dr. Garavito's therapy concentrated on her neck and low back. In time, Petitioner testified, her low back pain got better, but the pain in her neck and left shoulder did not.

On July 6, 2015, Dr. Becerra noted that Petitioner complained of left shoulder pain. The left arm felt "heavy" and moving it was painful. Dr. Becerra ordered a left shoulder MRI. (Px 5, p. 34) Petitioner testified that Dr. Becerra had focused on her arm at that time because it was swollen. The MRI, taken on July 21, 2015, showed a distal supraspinatus tear along with rotator cuff tendinosis, and a Type II acromion. (Px 5, p. 38) Based on the MRI, Dr. Becerra referred Petitioner to orthopedic surgeon Chandrasekhar Sompalli, M.D., for an orthopedic opinion. Dr. Becerra also prescribed Norco, Medrol Dosepak, and continued physical therapy. (Px 5, p. 30)

4. **Surgical recommendation from Dr. Sompalli**

On July 28, 2016, Petitioner first presented to Dr. Sompalli. (Px 2, p. 5) After examining Petitioner and reviewing her MRI, Dr. Sompalli took her off work and recommended arthroscopic surgery. (*Id.*, pp. 6-7)

Petitioner testified that she underwent left shoulder surgery on August 15, 2015, which was paid

for by Respondent's workers' compensation carrier. Dr. Sompalli's operative report documents a Type II SLAP tear of the glenoid labrum, as well as a rotator cuff tear of the supraspinatus that involved about 15% of the bursal surface. (Px 2, p. 21) Dr. Sompalli repaired the SLAP tear, and debrided the partial rotator cuff tear. He also performed a subacromial decompression and partial acromioplasty. (*Id.*)

5. **Post-surgical course, cervical treatment, and second shoulder surgery recommended**

Petitioner resumed physical therapy at Midwest Medicorp on August 17, 2015, a week following surgery (Px 3, p. 37) and continued through December 21, 2015 (*Id.*, p. 65). She testified that her neck pain continued after surgery. On September 15, 2015, Dr. Sompalli continued her physical therapy, prescribed Dilaudid for pain, and referred her for a cervical evaluation. (Px 2, p. 112)

Petitioner also reported neck pain to Dr. Becerra, her family doctor, whom she saw on September 18, 2015. (Px 5, p. 27) Dr. Becerra ordered a cervical MRI, completed November 12, 2015, which showed spondylosis and disc bulges at C3 through C6. (*Id.*, pp. 40-41) She referred Petitioner to spinal surgeon Jeffrey K. Wingate, M.D., who recommended epidural steroid injections. (Px 4, pp. 15-17) Dr. Wingate referred Petitioner to a pain specialist, Krishna Chunduri, M.D., who diagnosed disc herniations with radiculopathy, and prescribed injections at C3 and C4. Drs. Wingate and Chunduri opined that Petitioner's cervical symptoms were related to her work injury. (*Id.*, pp. 17; 21-22) Petitioner testified that she never got the injections because they were not approved by Respondent's workers' compensation carrier.

Petitioner testified that she returned to work from November 30, 2015 to December 9, 2015. Respondent provided light-duty work in which she did paperwork in the office. However, her pain increased. On December 9, 2015, Dr. Sompalli took her back off work and TTD resumed. (Px 2, p. 124)

On December 21, 2015, Petitioner reported increased pain in her left shoulder to her therapist at Midwest Medicorp. (Px 3, p. 65) She consulted Dr. Sompalli the next day, December 22nd, and reported moderate swelling and severe pain in her left shoulder. (Px 2, p. 127) Dr. Sompalli ordered an MRI arthrogram, discontinued physical therapy pending the results, and kept Petitioner off work. (*Id.*, p. 128)

The MRI arthrogram was carried out on January 4, 2016. (Px 2, pp. 133-34) On January 12th, Dr. Sompalli reviewed the results and found a recurrent, anterior-superior labral tear, as well as a partial supraspinatus tear that was now over 50%. (*Id.*, p. 138) Dr. Sompalli took her off work and recommended a second surgery, which was scheduled for January 27, 2016. (*Id.*, p. 139)

Petitioner testified that she has not undergone such surgery as the workers' compensation carrier has not approved it.

6. **Respondent's Section 12 exam**

On February 1, 2016, Respondent had Petitioner evaluated by John Cherf, M.D., pursuant to Section 12. Petitioner testified that this examination lasted about 15 minutes and included x-rays. She testified that she complied with Dr. Cherf's requests and gave her best effort.

In his report to Respondent, Dr. Cherf opined that the mechanism of injury was "not typical of causing labral tears" or rotator cuff pathology, and he would therefore consider these pre-existing. (Respondent's Exhibit "Rx" 1, Dep. Exhibit 2, p. 4) He also commented that Petitioner's subjective complaints seemed excessive in light of his objective findings, in particular the lack of atrophy in her left arm, which would suggest it was being used. (*Id.*, p. 5) However, because Petitioner had no shoulder pain prior to her injury, Dr. Cherf did find a causal connection between the accident and her symptoms. (*Id.*, p. 4)

Dr. Cherf's diagnosis was a work-related left shoulder contusion. He also diagnosed a labral tear and partial-thickness rotator cuff tear that he found to be unrelated, as they "most likely" predated the accident and thus did not represent "acute pathology." (*Id.*, p. 5) Further care recommended by Dr. Cherf included ice, home exercises and a possible steroid injection to the left shoulder, along with light-duty restrictions. He estimated that Petitioner should reach maximum medical improvement 6-8 months after her surgery, or by April 10, 2016. Dr. Cherf did not appear to be aware of Dr. Sompalli's recommendation for further surgery.

Dr. Cherf opined that Petitioner's prognosis following her labral surgery was unclear. He wrote that some patients "experienced pain and limitation of motion after labral repair." He also wrote: "Hopefully, Ms. Castellanos is able to resume fairly normal function with a little more time." (*Id.*, p. 6)

On March 23, 2016, Dr. Cherf authored an addendum to his Section 12 report. (Rx 1, Dep. Ex. 3) Dr. Cherf did not re-examine the Petitioner. His report stated he had reviewed the MRI arthrogram of January 5, 2016 (*sic*) as well as Dr. Sompalli's records. However, specific reference was made only to the findings of the original MRI on July 21, 2015. Dr. Cherf reiterated that this had shown a partial thickness rotator cuff tear but no "acute pathology." (*Id.*, p. 1) He also repeated his opinion that the mechanism of injury was "not consistent with causing labral pathology or a rotator cuff tear. For this reason, I do not recommend any further surgical intervention of Ms. Castellanos' left shoulder." (*Id.*, pp. 1-2)

7. **Petitioner's attempt to return to work and termination by Respondent**

Based on Dr. Cherf's report, Respondent discontinued TTD on February 11, 2016. The Petitioner testified that she returned to work "after the doctor from insurance told me I could go back." She recalled working another 5 or 6 weeks, until about March 28, 2016.

Dr. Sompalli saw Petitioner on March 1, 2016 and noted surgery has not been approved. He recommended against a cortisone injection as it might lead to worsening of the partial rotator cuff tear. (Px 2, pp. 150-151) Dr. Sompalli kept Petitioner off work, continued to recommend surgery, and placed a hold on P.T. On March 29, 2016, Dr. Sompalli saw Petitioner for ongoing left

shoulder pain and swelling. Dr. Sompalli noted that forward flexion and abduction of the left shoulder were limited to 90° with pain. (*Id.*, p. 154) Dr. Sompalli repeated his recommendation for surgery and noted that she "was told to work following another assessment and was unable to work." (*Id.*, p. 154) Dr. Sompalli wrote a note taking Petitioner off work through April 26, 2016. (*Id.*, p. 155) On April 22, 2016, Dr. Sompalli issued work restrictions limiting Petitioner to one-handed work with her right arm. This restriction would be permanent "until after surgery." (*Id.*, p. 161) Petitioner did not receive any additional TTD benefits.

Petitioner identified Petitioner's Exhibit 10 as a letter from her employer, signed by plant manager Tim Seymour and dated April 29, 2016. She testified that she received it via FedEx. Before that, she had been summoned to a meeting with employer representatives Roberto Marquez, Cindy and Christine Trocellier. Petitioner testified that they told her they had no light duty and that "I was not allowed to come back to the company, that I got to leave." The letter stated that Petitioner had been off work since March 31, 2016 and had exhausted her FMLA leave. The letter also stated in pertinent part, the following: "However, in light of the fact that your doctor has deemed your restrictions permanent and that it is unclear if or when any surgery will be scheduled, Greif cannot continue to provide you with unpaid leave as an accommodation for the indefinite future. Consequently, your employment with Greif is terminated effective April 29, 2016." (Px 10)

8. <u>Petitioner's current condition</u>

Petitioner remained under the care of Dr. Sompalli, who continued to recommend surgery. On May 10 and July 5, 2016, Dr. Sompalli noted continued swelling, weakness and severe pain in Petitioner's left shoulder, and that surgery continued to be denied by the insurance carrier. He maintained her one-handed work restrictions. (Px 2, pp. 163-167) On August 30, 2016, Dr. Sompalli administered a cortisone injection for pain relief. He continued to recommend surgery; however, he also prescribed a Functional Capacity Evaluation ("FCE") to assess Petitioner's abilities in the interim. (*Id.*, pp. 171-172).

Petitioner completed the FCE on September 2, 2016. The report found her functioning at a light level with maximum lifting of 15 pounds occasionally and 3 pounds on a constant basis. This was judged as below the demands of her job, described as "factory helper—medium physical demand." (Px 3, p. 71) On September 16, 2016, Dr. Sompalli found Petitioner's condition largely unchanged, while noting pain relief of about 30% from the steroid injection. (Px 2, p. 182) On reviewing the FCE, Dr. Sompalli renewed Petitioner's restriction to one-handed work, with a maximum lifting capacity of 2 pounds with the left arm. (*Id.*, p. 184) He also renewed his prescription for surgery. (*Id.*, p. 183)

The Petitioner testified that she had not returned to work in any capacity since her dismissal by Respondent and has not received any additional TTD benefits. She testified that she continues to have left shoulder pain, radiating to her neck, which interferes with her sleep. Her left arm swells if she sits too long. The injection given to her by Dr. Sompalli in August 2016 helped, but only a little. Petitioner confirmed that she has had no further accidents or injuries to her neck, back or left shoulder subsequent to June 19, 2015.

Petitioner testified that she did not undergo the second surgery because of the lack of insurance

approval. She also did not undergo the cervical injections for the same reason. She takes a lot of Advil to manage the pain. She is unable to do most household chores, and she cannot hold her smaller grandchildren. Her daughter helps with the chores she is unable to do. Petitioner testified that she would have surgery if workers' compensation would pay for it, and would also have the cervical injections prescribed by Drs. Chunduri and Wingate.

9. **Deposition of Dr. Sompalli**

Dr. Sompalli, the treating surgeon, testified by evidence deposition on November 3, 2016. (Px 1) Dr. Sompalli is a board-certified orthopedic surgeon, specializing in sports medicine. (*Id.*, pp. 4-5) About 20% of his practice consists of shoulder surgeries, of which he performs about 140 per year. (*Id.*, p. 6) He has testified in workers' compensation cases in the past, but does not perform independent medical exams. (*Id.*, pp. 6-7)

Dr. Sompalli testified that Petitioner's complaints of left shoulder and neck pain were consistent with his physical examination as well as with what he saw on her July 21, 2015 MRI. (*Id.*, p. 11) The MRI revealed a supraspinatus tear with moderate tendinosis. Dr. Sompalli's original diagnosis was a rotator cuff strain or partial tear, and he recommended arthroscopic surgery. (*Id.*) He testified that during the surgery, in addition to a 15% partial tear of the supraspinatus, he found a Type II labral or SLAP tear. (*Id.*, p. 12) He repaired this tear using suture anchors. Because the rotator cuff tear was small, he debrided it, which means he removed the torn fibers. (*Id.*)

Dr. Sompalli opined that both the SLAP tear and the partial rotator cuff tear were likely pre-existing, and that they had been aggravated by Petitioner's workplace accident. (*Id.*, pp. 15-17) He testified that she had no history of injuries or work restrictions prior to the accident. (*Id.*, p. 10) Regarding the mechanism of injury, he testified that a direct blow to the shoulder can displace the head of the humerus, causing it to move out of its socket. (*Id.*, p. 16) It can also cause the acromion process to move, resulting in impingement. (*Id.*, p. 30)

Dr. Sompalli opined that the surgery was reasonable, necessary and causally related to Petitioner's workplace accident. (*Id.*, p. 20) He testified that he debrided Petitioner's rotator cuff tear rather than repairing it because the tear was less than 50%. In such cases, ⅔ of patients will never develop a full tear. (*Id.*, p. 13) Dr. Sompalli offered several articles from professional journals in support of this approach. (*Id.*, Dep. Exhibits 3-5)

Following surgery, Dr. Sompalli testified, Petitioner's shoulder function did not improve as expected, despite several months of physical therapy. In September 2015, he referred her to a spinal surgeon for her ongoing neck symptoms. On December 22, 2015, he stopped the physical therapy and ordered a repeat MRI because her left shoulder pain had become severe. (*Id.*, pp. 20-21) Dr. Sompalli testified that the MRI results showed that Petitioner's SLAP tear had failed to heal. He testified that this can happen for several reasons, including the nature of the tear, physical therapy or other factors. About 33% of SLAP tears fail to heal. (*Id.*, p. 23) In addition, Dr. Sompalli found that Petitioner's partial rotator cuff tear had increased in size from 15% to about 50%. (*Id.*, p. 23) This made surgical repair necessary, along with debridement of the SLAP tear. (*Id.*, pp. 24, 26) Dr. Sompalli testified that Petitioner had reported no additional trauma to her shoulder following her work accident. (*Id.*)

Dr. Sompalli testified that Petitioner's condition had not improved in the months since her second MRI. He continued to recommend that she undergo repeat surgery, and remain off work in the interim. (*Id.*, p. 26) Following surgery she could expect to reach maximum medical improvement in 4-6 months. (*Id.*, p. 27) This second surgery, like the first, would be causally related to Petitioner's original work accident. (*Id.*, p. 28)

10. Deposition of Dr. Cherf

Dr. Cherf testified by evidence deposition on November 8, 2016. (Rx 1) He is a board-certified orthopedic surgeon, specializing in sports medicine. Dr. Cherf testified that he practices medicine only part-time, the other 50% of his schedule being devoted to governance and administrative work. (*Id.*, p. 6). Medico-legal exams comprise about 25% of his medical practice, 95% of which are for the defense. (*Id.*, p. 7) Dr. Cherf is also board chairman of Ortho-Centrix Solutions, a company that solicits and arranges independent medical exams, including the one at issue. (*Id.*, pp. 8, 55-56)

Dr. Cherf described the mechanism of injury involved in Petitioner's workplace accident as having "backed up into a metal object that hit her shoulder." (*Id*, p. 34) He did not know the size of the object or the speed or momentum of the impact. (*Id.*, p. 61) However, he opined that this would have resulted only in a contusion, and that Petitioner's left shoulder MRI, taken a month after the injury, had failed to show signs of a severe contusion. (*Id.*, pp. 34-35) Dr. Cherf reiterated his opinion that Petitioner's rotator cuff and SLAP injuries were entirely pre-existing and unrelated to her June 19, 2015 accident. He opined: "if you had taken this MRI on June 18, 2015 you would have had the same findings." (*Id.*, p. 64)

Dr. Cherf agreed that Petitioner had a partial thickness rotator cuff tear, and a SLAP tear or labral tear. (*Id*, pp. 63-64) He testified that he would not have done surgery, but would not say that Dr. Sompalli was unreasonable to do so. (*Id.*, pp. 58-59) Dr. Cherf described the 15% rotator cuff tear documented on Petitioner's operative report as "normal for a 51-yr-old." (*Id.*, p. 68) He opined that a second surgery was not warranted to address Petitioner's ongoing symptoms (*Id.*, p. 48) and expressed doubt as to the general usefulness of surgery for degenerative, age-related tears in persons over 40. (*Id.*, p. 38) Dr. Cherf agreed that Petitioner, per her history, had no history of prior left shoulder symptoms or treatment, and had been working full-duty at the time of her accident. (*Id.*, pp. 60-61)

CONCLUSIONS OF LAW

The Arbitrator incorporates by reference the preceding findings of fact, and concludes:

In support of his decision with regard to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds as follows:

Employers take their employees as they find them. *St. Elizabeth's Hospital v. Ill. Workers' Comp. Comm'n,* 371 Ill. App. 3d 882, 888 (5th Dist. 2007). Evidence of a pre-existing condition does not prevent recovery if the pre-existing condition was aggravated or accelerated by a work-related injury. *Tower Automotive v. Ill. Workers' Comp. Comm'n*, 407 Ill. App. 3d 427, 434 (1st Dist. 2011). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor. *Rock Road Construction v. Indus. Comm'n*, 37 Ill.2d 123, 127, 227 N.E.2d 65 (1967)

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. Indus. Comm'n*, 93 Ill.2d 59, 63-64 (1982)

In this case, the evidence shows that prior to the June 19, 2015 accident, Petitioner was capable of performing the full duties of her job with Respondent. Respondent's Section 12 examiner agreed that, per her history, Petitioner's left shoulder had been asymptomatic and she experienced no left shoulder injuries prior to the date of accident. Petitioner testified that she had no prior injuries or workers' compensation claims, and had worked for several years in the position of Helium Tester without restriction. According to Respondent's own job description, this position required repetitive use of the arms and hands, as well as lifting up to 50 pounds for 33% of the time. (Px 9)

When she first sought treatment on June 22, 2015 at Ingalls Occupational Health, the physician there recorded that Petitioner stated she injured herself while picking up a drum at work, but made no mention of a piece of steel striking her in the back. The next day, however, Dr. Garavito recorded that Petitioner had been struck by a tube in the left shoulder and mid-back area while lifting a drum at work.

On June 24, 2015, when Dr. Becerra saw Petitioner, she recorded that on June 19, 2015, Petitioner bent over to pick up a drum and on getting up, struck her back on a metallic tube and felt pain in her upper left back and that the pain was intense and she felt like fainting. Dr. Becerra examined Petitioner and found, *inter alia*, tender cervical muscles, left more than right, a mild bruise over the medial aspect of the left scapula with muscle spasm and tenderness, tender on arm ROM, decreased hand grip on left hand and left arm strength 4/5 vs. right arm strength 5/5.

Respondent accepted the accident.

Following the date of injury, Petitioner was continuously placed off work or confined to restricted duty by her treating physicians, all of whom found objective evidence of injury to her left shoulder/arm, neck and back. Petitioner testified that following the work accident, her back pain

resolved over time but her neck and left shoulder pain continues. This testimony is corroborated by the medical records.

No evidence was presented that Petitioner was ever disciplined at work.

Even if one of the medical witnesses was equivocal on the question of causation, it is for the Commission to decide which medical view is to be accepted, and it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n.*, 77 Ill. 2d 1, 394 N.E.2d 1166 (1979) citing *Holiday Inns of America v. Indus. Comm'n*, 43 Ill.2d 88, 89-90 (1969); *Proctor Community Hospital v. Indus. Comm'n*, 41 Ill.2d 537, 541 (1969).

In this case, the Arbitrator finds the opinions of the treating physicians to be more persuasive than those of the examining physician. Both Dr. Sompalli and Dr. Cherf agree that Petitioner's labral tear and rotator cuff tear were pre-existing conditions. Dr. Cherf believed that the mechanism of injury would not "typically" cause the labral tear and rotator cuff pathology that was shown on Petitioner's July 2015 MRI. The Arbitrator notes that, interestingly, Dr. Cherf was completely silent as to whether the work accident aggravated her pre-existing condition. However, unlike Dr. Cherf, Dr. Sompalli was more comprehensive in his discussion of the mechanism of injury. He opined that a direct blow to the posterior shoulder can displace the joint forward, which can aggravate Petitioner's underlying but previously asymptomatic shoulder pathology. (Px1, pp. 16, 20, 30) Dr. Sompalli also provided medical literature to support this conclusion. (Px 1, Dep. Ex. 5, p. 3)

Dr. Sompalli testified that, in general, he finds the mechanism of injury in this case to be consistent with the aggravation of her pre-existing conditions. (Px 1, p. 20)

When an employee with a pre-existing condition is injured in the course of his employment, serious questions are raised about the genesis of the injury and resulting disability. The Commission must decide whether there was an accidental injury which arose out of the employment, whether the accidental injury aggravated or accelerated a pre-existing condition or whether the pre-existing condition alone was the cause of the injury. Generally, these will be factual questions resolved by the Commission. However, the Commission's decision must be supported by the record and not based on mere speculation or conjecture. If there is an adequate basis for finding that an occupational activity aggravated or accelerated a pre-existing condition, and thereby caused the disability, the Commission's award of compensation must be confirmed. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 797 N.E.2d 665 (2003).

Dr. Cherf concluded that the workplace injury had been a simple shoulder contusion. The Arbitrator finds that this opinion is not persuasive. None of Petitioner's medical providers diagnosed her shoulder injury as a mere "contusion." Dr. Cherf also concluded that Petitioner's symptoms were diffuse and nonspecific given his reading of the January 2016 MRI. (Rx 1, pp. 48-49) First, the Arbitrator notes that Dr. Cherf never provided his reading of the January 2016 MRI and only noted that he reviewed it. Second, the Arbitrator is not persuaded by Dr. Cherf's opinion that Petitioner's presented with abnormal illness behavior (Rx 1, pp. 28, 71, 72) No other doctor or other medical professional found Petitioner's presentation to be abnormal. In fact, Dr. Sompalli testified that Petitioner's symptoms were consistent with his examination findings and the MRIs.

Also, Dr. Chunduri (in treating Petitioner's cervical radiculopathy) stated that "the site of this problem does correlate well with left shoulder scapular pain." (Px 4, p. 22)

Dr. Cherf also attempted to discredit Petitioner's claim by pointing to the lack of bone or soft-tissue edema on Petitioner's July 2015 MRI, which would suggest that her original injury could not have been serious. The Arbitrator notes that the MRI was taken more than 1 month after the injury. Dr. Cherf also attempted to use the lack of muscle atrophy in Petitioner's left arm to cast doubt on the severity of her injury. The Arbitrator notes that Petitioner participated in physical therapy both before and after her shoulder surgery.

Dr. Cherf found an inconsistency between Petitioner's active range of motion (performed by Petitioner) and her passive range of motion (conducted by Dr. Cherf). Dr. Cherf could not explain such inconsistency.

Dr. Sompalli's opinions are supported by the medical records of the Ingalls company clinic, the physical therapy clinic, Petitioner's family physician (Dr. Becerra), Dr. Wingate, and Dr. Chunduri. Finally, Dr. Sompalli's role as Petitioner's treater over the course of a year gives greater weight to his opinions than those of Dr. Cherf, who saw Petitioner for a single examination well after her accident and initial surgery.

The Arbitrator considers the fact that Dr. Cherf conducts approximately 95% of his IMEs on behalf of respondents. (Rx 1, p. 53)

The Arbitrator notes that when Petitioner saw her family doctor, Dr. Becerra, on June 14, 2016 and July 11, 2016, she voiced complaints of other conditions, but made no complaints of shoulder or neck pain. (Px 5, pp. 14-16)

With regard to Petitioner's cervical spine, the Arbitrator relies on the opinions of Petitioner's treating physicians, Dr. Wingate and Dr. Chunduri. Respondent's examiner, Dr. Cherf, did not provide any opinions regarding Petitioner's cervical spine (Rx 1, pp. 74-75) and Dr. Sompalli testified that he would defer to Drs. Wingate and Chunduri. (Px 1, pp. 21-22) The objective evidence supports Petitioner's claim as the November 2015 MRI showed disc bulges at C3-6 with impingement of the exiting nerve roots and disc bulges at C5-7 disc spaces causing narrowing of the bilateral neural foramen. (Px 4, p. 13) Dr. Wingate opined that the mechanism of injury of hitting the metal bar was causally related to her cervical radiculopathy. (Px 4, p. 17) Dr. Chunduri agreed and noted that Petitioner's left-sided neck and shoulder pain were likely the result of an injury at C3-4 where there is a disk protrusion with impingement. As such, Dr. Chunduri recommended a left-sided C3-4 injection. (*Id.*, pp. 21-22) Respondent did not submit any medical opinions to dispute causation of Petitioner's cervical spine.

Every natural consequence that flows from an injury that arose out of and in the course of one's employment is compensable under the Act absent the occurrence of an independent, intervening accident that breaks the chain of causation between the work-related injury and an ensuing disability or injury. *National Freight Industries v. Ill. Workers' Comp. Comm'n*, 993 N.E.2d 473, 373 Ill. Dec. 167 (5th Dist. 2013)

In the case at bar, no such independent, intervening accident occurred.

Based on the foregoing, including the chain of events, by a preponderance of the weight of the evidence, the Arbitrator finds that Petitioner's current conditions of ill-being of her left shoulder, neck and back are causally related to the accident of June 19, 2015. Petitioner testified that her back pain has resolved.

In support of his decision with regard to issues (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", and (K) "Is Petitioner entitled to any prospective medical care?", the Arbitrator finds as follows:

The Arbitrator notes that no utilization reviews were submitted to challenge the reasonableness and necessity of the care undergone by Petitioner to date.

With regard to Petitioner's left shoulder, Dr. Cherf agreed with Dr. Sompalli's diagnosis of a SLAP tear and partial rotator cuff tear. Dr. Cherf also agreed that physical therapy and other conservative measures were appropriate treatments. While Dr. Cherf testified that he personally would not have operated on Petitioner's left shoulder in August 2015, he declined to state that Dr. Sompalli was unreasonable in doing so. (Rx 1, pp. 72-73)

During surgery, Dr. Sompalli found a type 2 SLAP tear and a partial bursal surface rotator cuff tear of 15% of the bursal side rotator cuff and supraspinatus and infraspinatus. Based on his operative findings, Dr. Sompalli performed a SLAP tear repair and debridement of the rotator cuff tear. Dr. Sompalli explained (and provided supporting medical literature) that a partial cuff tear less than 50% thickness requires debridement versus repair as a third of such tears do not progress to full tears. (Px 1, p. 13; Dep. Exhibits 3-4) Dr. Cherf agreed that tears under 50% are rarely treated with a repair. (Rx 1, p. 78) Dr. Sompalli's post-operative care is supported by the medical literature he provided during his deposition. (Px 1, Dep. Ex. 5, Table 4)

Petitioner's MR arthrogram of January 4, 2016 showed a partial thickness articular surface tear of the supraspinatus tendon up to 50% and an anterior and superior labral tear. (Px 2, p. 133) Dr. Sompalli explained that the SLAP tear previously repaired had not healed. He elaborated that up to 33% of SLAP tears may not heal due to the repair itself, physical therapy or due to the individual's body. (Px 1, p. 23). Dr. Sompalli also opined that the January 2016 MRI showed that the rotator cuff tear had increased from 15% to 50%. Dr. Sompalli recommended surgery to repair the rotator cuff tear as a majority of tears at 50% or greater progress into full tears. (*Id.*, pp. 23-24; Dep. Ex. 3, pp. 4-5; Dep. Ex. 4, pp. 2-4; 6) With regard to the SLAP tear, Dr. Sompalli explained that there was no benefit to repairing both the rotator cuff tear and the concomitant SLAP tear, which is why he recommended debridement versus repair of the SLAP tear. (*Id.*, p. 26). Dr. Sompalli also provided medical literature to support his treatment recommendation. (Id., pp. 23-26; Exhibits 3-4). While Dr. Cherf did not provide his reading of the January 2016 MRI, he agreed that a repair is reasonable for tears over 50%. (Rx 1, p. 78)

With regard to Petitioner's back and neck complaints, Respondent did not offer any medical

opinions to dispute the reasonableness and necessity of past treatment nor the need for future medical care. Petitioner's back complaints are now resolved and she requires no additional care. Both Drs. Wingate and Chunduri have opined that based on Petitioner's MRI findings and complaints of pain, she requires injections to treat her cervical radiculopathy.

Dr. Sompalli testified that he finds the need for the surgery he performed on August 10, 2015 to be necessary, reasonable and related to Petitioner's work accident. (Px 1, p. 20)

As he has found Petitioner's left shoulder, neck and back conditions to be causally related to her work accidents, the Arbitrator finds the medical charges in Petitioner's Exhibit 8, totaling $67,745.23, to be reasonable and necessary care. As such, they are Respondent's liability, pursuant to Section8(a) and subject to Section 8.2 of the Act. Petitioner has agreed that Respondent has paid $50,986.87 for other benefits. (Ax 1)

The Arbitrator also finds the second surgery prescribed by Dr. Sompalli and the cervical injections prescribed by Drs. Wingate and Chunduri to be reasonable and necessary care, in accordance with Section 8(a) of the Act and *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill. App. 3d 705, 691 N.E.2d 13 (1997).

The Arbitrator orders Respondent to authorize and pay for the surgery that Dr. Sompalli has recommended as well as the injections that Dr. Chunduri has prescribed.

In support of his decision with regard to issue (L) "What temporary benefits are in dispute? TTD", the Arbitrator finds as follows:

The parties stipulated that Petitioner was entitled to TTD benefits from June 24, 2015 through November 30, 2015 and from December 10, 2015 through February 11, 2016. Petitioner claims entitlement to additional TTD benefits from March 31, 2016 through December 19, 2016, the date of trial, for a total of 69-5/7 weeks.

The Arbitrator notes that TTD benefits were discontinued pursuant to Dr. Cherf's report dated February 1, 2016. (Rx 1, Dep. Ex. 2)

In addition, in a letter dated April 29, 2016 (Px 10), Mr. Tim Seymour, Plant Manager for Respondent, specifically stated that work within Petitioner's restrictions was not available. Mr. Seymour also wrote that at a meeting attended by Petitioner and Roberto Marquez, Petitioner stated that no shoulder surgery had been scheduled and that she did not know if or when such surgery would be scheduled.

Petitioner testified that she has not undergone this second left shoulder surgery due to lack of approval by the work comp. carrier.

Dr. Sompalli has continued to recommend arthroscopic surgery to Petitioner's left shoulder.

Respondent terminated Petitioner's employment, effective April 29, 2016. (Px 10) This

termination letter noted that Petitioner's last day of work was March 31, 2016.

Petitioner has agreed that Respondent has paid $23,564.03 in TTD benefits. (Ax 1)

The Arbitrator finds that Petitioner is entitled to TTD benefits from June 24, 2015 through November 30, 2015, from December 10, 2015 through February 11, 2016 and from March 31, 2016 through December 19, 2016, which was the date of trial. Respondent is entitled to a credit of $23,564.03 for TTD benefits paid.

Brian T. Cronin
Arbitrator

5-16-2017
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

Albert Chester, Jr.,
Petitioner,

vs. NO: 11WC 4487

AT&T,
Respondent.

18IWCC0182

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 April 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 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: MAR 23 2018
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MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CHESTER JR, ALBERT
Employee/Petitioner

Case# **11WC004487**

AT&T
Employer/Respondent

18IWCC0182

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

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

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

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

0766 HENNESSY & ROACH PC
LAUREN A SERAFIN
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

Albert Chester, Jr.
Employee/Petitioner

v.

AT&T
Employer/Respondent

Case # **11** WC **04487**

Consolidated cases: **N/A**

18IWCC0182

An *Application for Adjustment 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 **2/24/2016**. 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 **10/1/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$43,778.80**; the average weekly wage was **$841.90**.

On the date of accident, Petitioner was **65** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$3,359.37** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent claims a credit for any short term disability benefits paid by Respondent under §8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner failed to prove that he was injured in an accident that arose out of and occurred in the course of his employment, and that Petitioner failed to that his condition of ill-being is causally connected to the alleged work accident.

Therefore benefits for medical expenses, total temporary disability, and permanent partial disability are denied.

Respondent receives §8(j) credit for any and all bills paid by group and a credit for $3,358.37 for TTD 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

April 5, 2017
Date

APR 5 - 2017

Albert Chester, Jr. v. AT&T
11 WC 04487

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?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? TTD; ***L:*** What is the nature and extent of the injury?

Petitioner and Tracy Vega testified at trial.

The Request for Hearing stipulation of the parties noted the claimed Date of Injury was October 1, 2010. Petitioner filed his Application for Adjustment of Claim February 8, 2011 (RX #7), for a December 6, 2010 work injury. On October 27, 2015 Petitioner filed his Amended Application for Adjustment of Claim (RX #8), amending the date of accident to October 1, 2010.

FINDINGS OF FACT

Petitioner Albert Chester, Jr. was employed as a premises technician for Respondent AT&T October 1, 2010. Petitioner had been working at that job since 2008. As a premises technician he installed video, phone, and internet services for residences. While installing these services Petitioner had to climb up utility poles while using ladders. If the ladder was too short, he had to climb up the pole with spikes to his work boots. After performing a service drop on the pole, he returned the ladder to the truck and he then would go inside the residence.

Petitioner testified that he carried his tools and equipment in his right, dominant hand. This included ladders, a laptop computer, and hand tools. Petitioner further testified that he wore a tool belt at all times, which weighed approximately 25 lbs. While working in residences, he needed to go up and down stairs several times. He also had to crawl in and out crawl spaces. He testified that 30% of the houses had crawl spaces he was required to go into.

Petitioner further testified that from 1979 to 2002 he was employed by Respondent as an assistant technician. The duties as an assistant technician were very similar to his duties as a premises technician. Petitioner testified that he wore a tool belt at all times during his job as an assistant technician.

Petitioner retired in 2002. When he returned to work for Respondent in 2008, his job duties changed to include cable and Internet service installation.

Petitioner testified that he started to develop right knee pain approximately 6 months prior to seeing Dr. Karen Wu at Loyola University Medical Center (Loyola) on October 1, 2010 (PX #2). Petitioner testified that he had seen his primary care physician, Dr. Wassim Atassi, for his right knee pain prior to seeing Dr. Wu (PX #5). Petitioner further testified that he couldn't recall when he saw Dr. Atassi but that Dr. Atassi referred him to Loyola for his right knee pain.

Petitioner had been a patient of Dr. Atassi from at least 2008 (PX #5). He had work-related elbow complaints in January 2010. The first notes of right knee complaints were on November 19, 2010. There is no documentation the right knee complaints were related to a work accident or injury. Dr. Atassi did note Petitioner's history of an injection. His impression, among other medical problems, was right knee osteoarthritis status post injection (see PX #2, October 1, 2010 note). A note on December 3, 2010 was much the same.

Dr. Atassi examined Petitioner for pre-operative clearance on May 26, 2011.

Petitioner testified that on October 1, 2010, he consulted Dr. Karen Wu at Loyola (PX #2 & RX #4). He testified that he complained of right knee pain for 6 months. Petitioner further testified that he reported his injury to his supervisor Lawrence Gaines and also, later, to David Wittington. He testified that AT&T employees are required to report their injuries immediately and that he knew those procedures.

Petitioner testified that he saw his primary physician, Dr. Atassi at Columbia Medical Center, for his right knee complaints. He testified that Dr. Atassi gave him an orthopedic referral to Loyola. He did not remember when he was given that referral but testified that it was before he saw Dr. Wu. There was no documentation that Dr. Atassi referred Petitioner to Dr. Wu or Loyola.

Dr. Atassi's records document Petitioner's complaints of right knee pain on November 19 and December 3, 2010 (PX #5). There were no notes relating Petitioner's complaints to his work activities. There was no note of an accident or an injury. The diagnosis was osteoarthritis, status post injection. Dr. Atassi returned Petitioner to

work without restrictions on both of those dates. Dr. Atassi cleared Petitioner for surgery on May 26, 2011.

Orthopedist Dr. Karen Wu evaluated Petitioner October 1, 2010 at Loyola (PX #2 & RX #4). At that time, Petitioner complained of right knee pain which had been present for 6 months. Petitioner denied a specific injury but indicated that he thought his pain was related to his work as a communication worker for AT&T, since he had been climbing poles since 2008. On examination, his gait was slightly antalgic. Knee extension was full but flexion was limited to 110°. There was minimal medial and lateral joint line tenderness. X-rays demonstrated near bone-on-bone disease in the medial compartment with small tricompartmental osteophytes.

Dr. Wu diagnosed osteoarthritis of the right knee but noted that Petitioner was feeling better after being off of work since September 22, 2010. Dr. Wu injected Petitioner's knee for pain relief. Petitioner was instructed to follow-up. Petitioner marked the October 1 intake information form that his complaints were not related to "Workman's Compensation". There is an indecipherable mark in the space to disclose if the complaints were the result of an injury. The space for date of injury is blank. Dr. Wu excused Petitioner from work beginning September 22 through October 4, 2010.

Petitioner testified that he was working at a second-floor apartment for Respondent on November 30, 2010. He testified that while walking down a dimly lit stairwell, he twisted his right knee. Following this incident, he called his supervisor at the garage and was instructed to go to Concentra Medical Center.

A Flash Report (RX #9), filled out by Tracy Vega, documents that on November 30, 2010, Petitioner was walking into a dim lit room and stepped on something that caused his right knee to twist.

On November 30, 2010, Petitioner was seen at Concentra Medical Center [Concentra] (PX #3). At that time, Petitioner reported a history of walking down the stairs in a poorly lit area when he twisted his right knee earlier that day. He complained of 7/10 knee pain. Minor swelling was noted but the remainder of the knee exam, including range of motion, was essentially normal. There was no report of injury or accident on October 1, 2010, or complaints before then. Petitioner was diagnosed with right knee strain and instructed to follow-up in 2 days. Petitioner was put on modified activity with no prolonged standing or walking, no squatting, no kneeling, and no climbing stairs or ladders.

On December 2, 2010, Petitioner returned to Concentra. He reported improvement in his pain but indicated that it was difficult for him to go down stairs.

Petitioner further indicated that he had not been working because there was no light-duty work available. Examination of the right knee was normal with full range of motion. Petitioner was diagnosed with knee strain and instructed to return in one week. His light-duty restrictions were continued.

On December 9, 2010, Petitioner returned to Concentra and reported ongoing right knee pain when going up and down stairs. Petitioner was referred for physical therapy and his light-duty restrictions were continued. At the physical therapy evaluation December 15 Petitioner denied previous injury or limiting condition to the knee prior to November 30, 2010. He had physical therapy at Concentra on December 15, December 16, December 20, December 22, and December 23, 2010.

On December 16, 2010 Petitioner saw Dr. McKnight at Concentra. He reported improvement with his right knee. Again, the examination was normal. Petitioner was discharged from Contra physical therapy because he had met his goals.

On December 23, 2010 Petitioner was re-evaluated by Dr. McKnight at Concentra (PX #3). He still had some pain in the knee when climbing stairs but felt that he was improving. Dr. McKnight diagnosed a knee sprain and determined that Petitioner had reached MMI for this injury. Dr. McKnight noted that Petitioner's ongoing pain was due to the arthritis in his right knee and that he should continue care with an orthopedic surgeon for that condition.

Petitioner testified that he wasn't provided work within his light-duty restrictions by Respondent from December 1, 2010 through December 23, 2010. Petitioner further testified that when he attempted to return to work for Respondent, his employment was terminated due to performance related issues. Petitioner testified that he was required to reach a 70% performance rating but could only do 65%. Petitioner testified that he wasn't able to reach the 70% due to his ongoing right knee pain. Petitioner testified that he never returned to work for Respondent after November 30, 2010.

On February 11, 2011, Petitioner returned to Dr. Wu at Loyola (PX #2). At that time, Petitioner reported a worsening of right knee pain when he jammed his right knee going down stairs at work on November 30, 2010. Right knee x-rays were performed which showed degenerative joint disease which was similar to the findings on October 1, 2010. Dr. Wu diagnosed a "flare" of right knee degenerative joint disease from injury. Dr. Wu provided Petitioner with a right knee injection and instructed Petitioner to continue with activity modifications. Petitioner was instructed to follow-up on an as-needed basis.

Petitioner followed up with Dr. Wu on April 8, 2011. At that time, Petitioner complained of worsening pain in his right knee. Petitioner reported that the prior steroid injection helped for only one week. There was no history of a new injury. Dr. Wu diagnosed osteoarthritis of the right knee and discussed surgical options with Petitioner. Dr. Wu recommended a diagnostic arthroscopy to determine what type of arthroplasty could be performed.

On May 31, 2011, Petitioner returned to Dr. Wu. At that time, Petitioner was requesting a steroid injection. Dr. Wu did not perform a steroid injection due to the potential of a UKA within the next 6 weeks. The right knee arthroscopy was scheduled.

Dr. Wu performed a right knee diagnostic arthroscopy at Gottlieb Memorial Hospital on June 27, 2011 (PX #4). The intraoperative findings were medial compartment grade 1 chondromalacia, grade 2 chondromalacia of the lateral tibia, and grade 2 patella chondromalacia. The post-operative diagnosis was osteoarthritis of the right knee.

On July 5, 2011, Petitioner was seen for a post-operative evaluation by Dr. Wu. At that time, Petitioner did not have pain and was walking without an assistive device. On examination, there was no swelling and the wounds were healed nicely. Dr. Wu's impression was right knee osteoarthritis in the medial compartment. After reviewing the arthroscopy findings, Dr. Wu determined that Petitioner was a candidate for a medial compartment UKA. Petitioner expressed his desire to move forward with that operation.

Dr. Eric Szczesniak performed a pre-operative history and physical exam at Loyola on August 4, 2011 (PX #2). Petitioner gave a history of right knee pain which began in April 2010. He reported a work injury in November 2010, which made his pain worse. On August 10, 2011, Petitioner underwent a right unicompartment knee arthroplasty by Dr. Wu. On August 11, 2011, Petitioner underwent an occupational therapy assessment at Loyola. He was recommended to undergo physical therapy once released. He was discharged from Loyola on August 12, 2011. On September 7, 2011, Dr. Wu wrote a script for physical therapy to evaluate and treat Petitioner's right knee.

Petitioner began post-operative rehabilitation therapy September 9, 2011 at Sports Orthopedic Rehabilitation, Inc (PX #6). A skilled course of physical therapy was recommended. Petitioner underwent physical therapy through December 3, 2011. At the time of his discharge on December 3, Petitioner reported no pain or discomfort at that visit. He was recommended to continue with home exercises.

On September 27, 2011, Petitioner returned to Dr. Wu and indicated he was feeling good. He was undergoing physical therapy and a home exercise program. Dr. Wu recommended Petitioner to complete his physical therapy, continue with the home exercise program, and to follow-up in August 2012. Petitioner returned to Dr. Wu on February 28, 2012. At that time, Petitioner reported no pain or other problems. Dr. Wu encouraged Petitioner to progress his activities as tolerated and to follow-up in August. The x-rays performed that day of the right knee showed good position of the UKA.

On September 25, 2012, Petitioner returned to Dr. Wu. At that time, Petitioner reported no problems or pain with the right knee but indicated that he had difficulty going up stairs which requires more effort than before. On examination, Petitioner's gait was normal, range of motion showed less than 5° flexion, and extension to 120° without pain. Dr. Wu indicated that Petitioner was doing well one year after the right knee medial UKA. Dr. Wu encouraged Petitioner to continue activities as tolerated and instructed Petitioner to follow-up in one year or sooner as-needed.

Dr. Wu did not note in Petitioner's clinical records that she associated Petitioner's right knee problems to anything other than degenerative osteoarthritis.

Petitioner further testified that he has ongoing discomfort in his right knee while going up and down stairs. He also has discomfort in his right knee when he ties his shoes. He can't stand in one place for more than one hour and fifteen minutes without experiencing right knee pain. He also feels discomfort and weakness in his right knee when he walks long distances. Petitioner further testified that he has not sustained any traumas to his right knee since the November 30, 2010 incident.

Petitioner testified that he was terminated in January 2011 for not meeting performance guidelines. He testified that the last time he visited Dr. Wu was September 25, 2012 and he was advised to follow up as needed. He has not returned to Dr. Wu since that date.

Tracy Vega testified that she worked for Respondent for 16 years in various management positions. She currently works for Respondent as an "ATO Development Coach." Ms. Vega testified that she was familiar with the Petitioner and has known him since 2008. She was Petitioner's direct supervisor in 2008.

Ms. Vega testified that all AT&T employees are aware of workplace reporting procedures, including needing to report their injuries within 24 hours. All injuries, even minor injuries that do not require medical treatment, need to be documented within twenty-four hours by a supervisor. All reported injuries are documented a database for

any supervisor's review. Ms. Vega testified that Petitioner would be knowledgeable in workplace accident reporting procedures.

Ms. Vega testified that on November 30, 2010, Petitioner reported a workplace injury. He reported that he was walking down the stairs in a dimly lit stairwell in a customer's home. He told her that he jammed his right knee. No prior knee pain or complaints or injury was reported. Once the injury was reported, Ms. Vega entered the work injury report into the database immediately, pursuant to AT&T guidelines.

Ms. Vega also testified that she reviewed the AT&T database when she was contacted to testify. There were 3 work injuries listed that Petitioner reported during his employment with AT&T: July 1, 2010 work injury from wasp stings; July 20, 2010 motor vehicle accident, and a November 30, 2010 knee twisting injury. No injury or complaint on October 1, 2010 injury was noted.

Ms. Vega testified that if there were any other injuries reported, it would be included on this report. Because no injury of October 1, 2010 was included on the report, Ms. Vega testified that she was confident that the Petitioner never reported any work injury on October 1, 2010. Further, no other knee injuries on any other day were reported. Ms. Vega testified that AT&T did not receive notice of an alleged October 1, 2010 injury until she was contacted to testify after the Application for Adjustment of Claim was amended in 2015.

At Respondent's request orthopedist Dr. Charles Bush-Joseph performed a §12 IME of Petitioner on November 18, 2011 (RX #1 & DepX #2). Dr. Bush-Joseph noted Petitioner's history of right knee pain from a work injury on November 30, 2010. Petitioner reported that he twisted his right knee while descending some stairs. Petitioner repeatedly denied that he did not have any symptoms or treatment before the November 30 work injury.

Dr. Bush-Joseph noted in his report Petitioner's history of evaluation by Dr. Wu on "October 6, 2010". He reviewed the records of Dr. Wu's injections, diagnostic arthroscopy, and partial arthroplasty. Dr. Bush-Joseph diagnosed Petitioner with severe degenerative knee arthritis and status post partial knee replacement with incomplete recovery. He opined that Petitioner's work activities may have aggravated or accelerated the osteoarthritis. He further opined that the November 30 work accident would have aggravated the pre-existing osteoarthritis symptoms, if not the organic disease. He noted that no clear evidence from diagnostic imaging suggested a material aggravation of the pre-existing arthritic condition from the November 30 accident.

Dr. Bush-Joseph authored an addendum report January 7, 2012 (RX #2 & DepX #3). He repeated his note that Dr. Wu's history on "October 6, 2010" recited Petitioner's denial of injury or trauma. He further noted Petitioner's bone-on-bone presentation and that Petitioner was destined for extensive treatment, including arthroplasty.

Dr. Bush-Joseph opined that the November 30, 2010 injury represented no more than a temporary aggravation of the osteoarthritic condition. He believed that Petitioner's condition, with or without any work injury, would have required a staging arthroscopy and eventual knee arthroplasty.

Dr. Karen Wu evidence deposition, July 11, 2013 (PX #1)

Dr. Wu's testimony was consistent with Petitioner's records (PX #2). She first saw Petitioner on October 1, 2010. Petitioner gave a history of right knee pain for 6 months. He also complained of swelling. He denied a specific injury but associated his complaints with his work. Dr. Wu diagnosed right knee osteoarthritis and administered a steroid injection.

Petitioner returned on February 11, 2011. Dr. Wu noted a typo in her record that he reported an injury "November 30, 2011", which she corrected to November 30, 2010. She opined that there was a flare-up of Petitioner's degenerative joint disease from his reported injury. Dr. Wu administered another injection.

Dr. Wu discussed surgery with Petitioner on several occasions. Petitioner initially rejected a total knee replacement and opted for a diagnostic arthroscopy.

Dr. Wu performed a right knee diagnostic arthroscopy of Petitioner on June 27, 2011. This procedure was performed to determine whether Petitioner was a candidate for a unicompartmental knee arthroplasty (UKA) since Petitioner was not interested in a total knee arthroplasty. She also performed a partial meniscectomy. Dr. Wu also noted bone-on-bone disease in the medial compartment, grade 2 chondromalacia of the patella, grade 1 chondromalacia of the lateral femoral condyle, and grade 2 chondromalacia of the lateral tibial plateau. Based on those findings Dr. Wu believed Petitioner should have the knee replacement.

Dr. Wu performed a partial arthroplasty on August 10, 2011. Dr. Wu testified that a patient would be off work following this type of procedure for 6 to 12 weeks. Petitioner had post-operative therapy. He returned on September 27, 2011, when he reported he was doing fine. In response to a hypothetical question, Dr. Wu opined that the physical activity described in the hypothetical, which incorporated activities

described by Petitioner in his trial testimony, could contribute to Petitioner's complaints of pain from the osteoarthritis and that the complaints of pain were the main contributing factor for the surgeries. Dr. Wu further testified that Petitioner would not have been able to perform the activities he had previously performed for Respondent following the arthroplasty.

On cross-examination Dr. Wu testified that she did not place specific work restrictions on Petitioner. She did not issue work restrictions because Petitioner did not ask for that. Dr. Wu did note that Petitioner would not have been able to return to full duty work because of his osteoarthritis.

Dr. Charles Bush-Joseph evidence deposition, December 4, 2013 (RX #3)

Dr. Bush-Joseph refreshed his memory from his reports (RX #1, DepX #2, RX #2, & DepX #3). He clarified certain typo errors: noting that Dr. Wu initially saw Petitioner on October 1, 2010, not October 6 and the last sentence of his November 18 report should be "produce" in place of "procedure",

Dr. Bush-Joseph opined that Petitioner had degenerative arthritis in the right knee which was appropriately treated with a knee replacement. He further opined that Petitioner sustained a temporary exacerbation on November 30, 2010, with no evidence of a material worsening of the pre-existing bone-on-bone arthritic condition. He further testified that Petitioner was only capable of working a sedentary level of activity at the time of the exam and that it was too difficult for him to opine if Petitioner would be able to have a full-duty release.

Dr. Bush-Joseph acknowledged that he would not do surgery if a patient with arthritis had no symptoms. He admitted that he did not have any opinions as to whether the repetitive work activities Petitioner performed were a contributing, aggravating or accelerating cause to his osteoarthritic condition. But he felt that ongoing job duties could cause Petitioner's symptoms, but would not produce a material worsening of a preexisting osteoarthritic condition.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove that he sustained an injury to his right knee that arose out of and in the course of his employment on October 1, 2010.

Any claim of this nature is dependent on the credibility of the evidence, particularly the credibility of the petitioner. Here, the Arbitrator finds Petitioner was not credible.

Petitioner's Application for Adjustment of Claim, filed February 8, 2011, stated Petitioner was injured on the job December 6, 2010. There was no evidence whatever that Petitioner claimed to be injured on that date. Petitioner filed an Amended Application for Adjustment October 27, 2015, stating he was injured on October 1, 2010. October 1, 2010 is the date of claimed injury on the Request for Hearing stipulation.

Petitioner's claim evolved over time from one based on a discrete injury to one of a manifestation of a cumulative, repetitive injury. The claimed manifestation date is October 1, 2010. On October 1 Petitioner consulted with orthopedic surgeon Dr. Karen Wu at Loyola University Medical Center. On October 1 Petitioner complained of right knee pain which began 6 months before. Petitioner testified at trial to that history. However, he did not testify that the problem which manifested in April 2010 progressed du to work activities. Further, there was no medical opinion with any degree of certainty that work activities in fact caused a progression of symptoms.

In addition, when Petitioner sought and received care for his right knee on November 30, 2010 at Concentra, there was no mention of a work accident or injury or complaint on October 1, 2010.

The only nexus of injury to work in the Loyola records is Petitioner's statement on October 1, 2010 that he thought his knee problems were related to his work. None of the Loyola physicians who consulted on Petitioner's case stated a specific causation opinion in the records. Any arguable causation opinion clearly related back to the lay, self-serving opinion of Petitioner. Dr. Wu's deposition testimony never quite rose to a level of certainty to satisfy the burden of proof that Petitioner's work activities caused or contributed to his knee problems. More important was Petitioner's responses on the patient intake history form on October 1, 2010, where he did not note an accident and specifically marked "no" for whether it was a Workman's Compensation claim.

Petitioner's credibility problems were otherwise highlighted by conflicting histories given to healthcare providers over time. At the pre-operative exam perform by Dr. Szczesniak on August 4, 2011, Petitioner recounted that his right knee pain began in April 2010 and that he had a work injury in November 2010. There was no mention of a work accident or manifestation of a cumulative problem in October 2010.

Petitioner's credibility is further undermined by his testimony that his primary physician, Dr. Atassi, referred him to Dr. Wu. There is no evidence of such a referral in either Dr. Atassi's chart or the Loyola chart.

There is evidence that Petitioner did sustain a work-related right knee injury November 30, 2010. That injury clearly aggravated a bone-on-bone arthritic condition in Petitioner's right knee. However, the claim before the Commission is one for an injury claimed on October 1, 2010. There is insufficient evidence to support a finding that Petitioner proved he was injured on October 1, 2010 or that the cumulative effects of work activities manifested in an injury on that date.

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

The Arbitrator finds that Petitioner failed to prove that he gave timely notice of the claimed October 1, 2010 to Respondent. The Arbitrator previously found that Petitioner was not a credible witness.

Petitioner gave varying reports about what was the onset of his right knee complaints. When he saw Dr. Wu at Loyola October 1, 2010 he did not give a history of a distinct accident or injury. When he saw Dr. Atassi on November 19, 2010 he did not mention a specific accident or injury or a manifestation date of October 1. In fact, on November 19 he did not report

Petitioner testified that he notified his supervisor, Lawrence Gaines, on October 1, 2010, that he was taken off work due to his right knee condition. Petitioner further testified that he reported a right knee injury to his supervisor on November 30, 2010.

Respondent's witness Tracy Vega testified credibly as she explained Respondent's policies and procedures for reporting work accidents. Petitioner confirmed that he knew those policies and procedures. Ms. Vega's testimony from Respondent's work accident database was convincing in showing there was no report of injury by Petitioner on October 1, 2010. Petitioner's testimony, in light of other credibility problems, was not convincing when he testified to his notice on October 1 to his supervisors that he had knee pain.

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

The Arbitrator notes that Respondent's §12 expert, Dr. Bush-Joseph, opined that Petitioner's pre-existing osteoarthritis could have been aggravated by Petitioner's work activities. However, the question of when remained open. That is not clear from the records or deposition testimony of Dr. Wu. There is insufficient evidence for the Arbitrator to find that Petitioner met his burden of proving any aggravation occurred or manifested on October 1, 2010. Finding causation here would be based on speculation

and not the evidence. Rather, the evidence supports a finding that Petitioner's condition of ill-being was from the natural progression of his pre-existing severe osteoarthritis.

Petitioner failed to present a qualified opinion that connected his condition of ill-being to his claimed repetitive work activities. In a repetitive trauma case, there must be a showing that the injury is work related and not the result of a normal degenerative aging process. Petitioner's burden of proof required a qualified expert's opinion that his right knee condition was related to his employment with Respondent. Petitioner's evidence failed to meet this burden of proof. Even without this failure, the Arbitrator finds, as stated before, Dr. Bush-Joseph opinion not connecting Petitioner's knee condition to Petitioner's work reasonable and persuasive.

For the reasons stated above, the Arbitrator finds that Petitioner failed to meet his burden of proof in regard to causal connection.

J: Were 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 previously found that Petitioner failed to prove that he had sustained an accidental injury that arose out of and in the course of his employment by Respondent. Therefore, the Arbitrator finds that the issue of reasonableness and necessity of Petitioner's medical care is moot.

K: What temporary benefits are in dispute? TTD

The Arbitrator previously found that Petitioner failed to prove that he had sustained an accidental injury that arose out of and in the course of his employment by Respondent. Therefore, the Arbitrator finds that the issue Petitioner's entitlement to total temporary disability benefits is moot.

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

The Arbitrator previously found that Petitioner failed to prove that he had sustained an accidental injury that arose out of and in the course of his employment by Respondent. Therefore, the Arbitrator finds that the issue Petitioner's entitlement to permanent partial disability benefits is moot.

April 5, 2017

Steven J. Fruth, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Judy Felz,
Petitioner,

18IWCC0183

vs.

NO: 13 WC 16556

State of Illinois-Jack Mabley Developmental Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of 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 August 29, 2017, is hereby affirmed and adopted.

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

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

MAR 23 2018

DATED:
o3/8/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0183

FELZ, JUDY A
Employee/Petitioner

Case# **13WC016556**

13WC016555
13WC016557

SOI-JACK MABLEY DEVELOPMENTAL CENTER
Employer/Respondent

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:

0021 REESE & REESE
TODD S REESE
979 N MAIN ST
ROCKFORD, IL 61103

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

6066 ASSISTANT ATTORNEY GENERAL
BRETT KOLDITZ
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
P O BOX 19208
SPRINGFIELD, IL 62794

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

AUG 29 2017

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

18IWCC0183

STATE OF ILLINOIS)
)SS.
COUNTY OF
LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Judy A. Felz
Employee/Petitioner

Case # 13 WC 16556

v.

Consolidated cases: 13 WC 16555
13 WC 16557

State of Illinois – Jack Mabley Developmental Center
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Ottawa**, on **July 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 **1/6/12**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner earned **$48,173.84**; the average weekly wage was **$926.42**.

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

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

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

Respondent shall be given a credit of **$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 credit **for medical bills paid through its group medical plan,** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, per Petitioner's exhibits 6 through 9 in the amount of $5,601.36, as provided in Sections 8(a) and 8.2 of the Act. – ARB EX 2 as stipulated.

Respondent shall pay Petitioner permanent partial disability benefits of $555.85/week for 15.375 weeks, because the injuries sustained caused the 5% loss of use of the right hand, as provided in Section 8(e) of the Act.

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

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

Carolyn M. Doherty

Signature of Arbitrator

8/24/17

Date

AUG 29 2017

FINDINGS OF FACT

Petitioner testified that on 1/6/12 she was working for the Respondent, State of Illinois, Jack Mabley Developmental Center. Petitioner's job duties required direct care for mentally handicapped and developmentally handicapped adults living at the facility, assisting in daily care, hygiene, emotional needs and teaching needs. Some of the handicapped individuals would become aggressive or combative at times and the staff would be required to use restraint techniques to calm the individual.

On 1/6/12, one of the handicapped individuals was trying to cause harm to himself and Petitioner assisted other coworkers in performing a 5-point physical hold to try and restrain the individual. One person held the individual's arms. Another person held the legs. Another person held the individual's head and Petitioner laid across the individual's torso. Her arms were also wrapped around the individual's legs. The individual was resisting the restraint and used his knees to hit Petitioner in her left side in her ribs causing pain. Petitioner also experienced pain in her right wrist, which was underneath the individual while he struggled, and she noticed lower back pain and pain in her right shoulder. Petitioner notified the employer, but did not seek medical treatment the same day and hoped that she would be fine. When the pain did not go away, she sought medical treatment three days later at KSB Corporate Health.

On 1/9/12, Petitioner testified and the medical records reflect that she was seen by Dr. Lyman Tieman at KSB Corporate Health. (PX 4). She described the incident with the uncooperative and combative resident at work and the subsequent injuries to her right hand, right shoulder and left ribs. She described pain with motion of the shoulder and that she had tenderness in the left ribs. On examination, she was tender to the left end of the lower anterolateral ribs and had tenderness to the right wrist over the distal ulna, as well as decreased range of motion and pain with the right shoulder. X-rays of the right shoulder, ribs and right wrist were all negative. Petitioner was assessed with contusions of the right wrist, right shoulder and left ribs. Petitioner was allowed to return to work without restrictions.

On 1/11/12, Petitioner testified and the medical records reflect that she followed-up with Dr. Tieman. Petitioner complained of 2-3/10 pain in the shoulder and wrist and was not feeling any pain in the ribs. On examination, she had full range of motion of the shoulder and some tenderness over the distal radius of the right wrist. She was continued on full duty.

On 1/20/12, Petitioner testified and the medical records reflect that she was seen again by Dr. Tieman. Petitioner's main complaint was right wrist pain. She stated that her right shoulder and rib pain had resolved, but that she continued to have right wrist pain with any stressful motion such as opening a jar. She also described having discomfort when she flexed, extended or deviated her right hand. On examination, she had tenderness over the volar radial aspect of the wrist and she had limited range of motion due to pain. Dr. Tieman placed Petitioner's right wrist in a splint and prescribed Motrin (ibuprofen) as well as physical therapy. Petitioner was given work restrictions of limited grasp up to three pounds and limited repetitive motion of the right wrist. Petitioner began physical therapy at KSB Hospital

On 2/3/12, Petitioner testified and the medical records reflect that she was seen again by Dr. Tieman. She indicated that she felt she was about fifty percent better and that physical therapy had helped improve her condition. She continued to wear the right wrist brace and had been staying within her prescribed restrictions and taking ibuprofen regularly. On examination, she had increased range of motion without significant pain on radial or ulnar deviation. Dr. Tieman continued physical therapy for another three weeks and planned to follow up aft that.

On 2/24/12, Petitioner had her final office visit with Dr. Tieman. She felt that she was 99% improved and that the physical therapy had greatly helped her. She was still wearing a right wrist splint on an intermittent basis, doing her home exercise program and staying within her work restrictions. On examination, she had full range of motion of the wrist without any evidence of pain or tenderness. Petitioner had one final therapy appointment, but she was released from treatment and advised to return on an as needed basis.

On 2/28/12, Petitioner testified and the medical records reflect that she completed her final physical therapy appointment. The impairment observation indicated that Petitioner had continued impaired range of motion and pain with gripping/pinching.

Petitioner testified as to what she currently notices about herself. She testified that she continues to have difficulty with her right wrist, especially lack of strength and dropping things. She described that gardening or "canning" vegetables causes too much strain on her wrist and she has not continued those activities. She used to crochet a lot, but now does not crochet because her wrist stiffens, she has loss of strength, loss of controlling the crochet tools and difficulty turning her wrist to crochet. She testified that she has not returned to Dr. Tieman for further treatment because she was told that there was nothing further he could do and that hopefully time would be beneficial. The Arbitrator finds Petitioner's testimony credible.

CONCLUSIONS OF LAW

With respect to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

The Arbitrator adopts and incorporates all the above findings of fact into these findings. The Arbitrator notes that Respondent does not dispute accident.

Petitioner was involved in a physical restraint with a handicapped individual at work who needed to be restrained. During the restraint of the agitated resident, Petitioner sustained injuries to her left ribs, right shoulder, lower back and right wrist. Petitioner immediately notified the employer and sought treatment within a few days of the incident. Petitioner gave consistent statements to her medical provider and had consistent complaints throughout her treatment. Petitioner testified that she did not have any prior problems with her right wrist, right shoulder, lower back or left ribs. Petitioner's testimony was unrebutted. The Arbitrator finds Petitioner's testimony credible.

Given the chain of events, the Arbitrator finds that Petitioner's conditions of ill-being for her right wrist, right shoulder, lower back and left ribs are causally related to the work accident on 1/6/12.

With respect to issue (L), the nature and extent of the injuries, the Arbitrator finds as follows:

The Arbitrator adopts and incorporates all the above findings of fact and conclusions of law into these findings.

In considering permanent disability in this matter, the Arbitrator shall base the determination on the following factors pursuant to Section 8.1(b) of the Act: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single factor shall be the sole determinant of disability. 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 are explained below. The Arbitrator initially notes that no reported level of impairment pursuant to Section 8.1b(a) was provided. The remaining enumerated factors were considered as follows.

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

With regard to subsection (ii) of Section 8.1(b), the occupation of the employee, the Arbitrator notes that Petitioner returned to work for Respondent after this accident full duty. Therefore, the Arbitrator gives no weight to this factor. With regard to subsection (iii) of Section 8.1(b), the age of the employee at the time of the injury, the Arbitrator notes that Petitioner was 44 years old at the time of the accident. With regard to subsection (iv) of Section 8.1(b), petitioner's future earnings capacity, the Arbitrator notes that no evidence was offered with regard to any impact this injury had on her future earning capacity. Petitioner was released to full duty work without restrictions. The Arbitrator gives no weight to this factor.

With regard to subsection (v) of Section 8.1(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained contusions to her right shoulder, left ribs and right wrist. Her medical treatment consisted of conservative treatment with right wrist bracing, physical therapy and pain medication. The final physical therapy record documents an impairment observation that Petitioner had continued impaired range of motion and pain with gripping/pinching. Petitioner testified that she continues to have difficulty with gripping items, strength of the right wrist and that she is unable to do certain activities that she used to participate in, such as crocheting. The Arbitrator finds that the evidence of disability is corroborated by the treating medical records and gives more weight to this factor.

Accordingly, the Arbitrator finds that Petitioner sustained permanency of 5% loss of use of the right hand, pursuant to Section 8(e) of the Act. The Arbitrator awards no permanency for Petitioner's left rib complaints as they were not subject to any medical treatment and resolved quickly without any evidence of disability.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JUDY A. FELZ,

Petitioner,

18IWCC0184

vs.

No: 13 WC 16557

STATE OF ILLINOIS – MABLEY DEVELEOPMENTAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent 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.

By way of background, Petitioner had three claims against Respondent, which were consolidated and arbitrated together. In 13 WC 16555, the Arbitrator found that Petitioner proved a work-related accident on September 3, 2011 causing an injury to her right eye, awarded medical expenses incurred ($466.00), but found that Petitioner did not sustain any permanency to the eye and denied permanent partial disability benefits. That decision is not being reviewed.

In 13 WC 16556, the Arbitrator found Petitioner proved a work-related accident on January 6, 2012 causing an injury to her right hand and awarded her medical expenses incurred and 15.375 weeks of permanent partial disability benefits representing loss of 5% of the right hand. That decision is affirmed and adopted in a separate decision.

In the instant claim, 13 WC 16557, the Arbitrator found Petitioner proved a work-related accident on February 16, 2013 causing injuries to her neck and low back and awarded her medical expenses incurred, 27&1/7 weeks of temporary total disability benefits, $3,374.36 in temporary partial disability benefits, and 100 weeks of permanent partial disability benefits representing loss of 20% of the person-as-whole.

In 13 WC 16557, the Commission affirms the Decisions of the Arbitrator regarding accident, causal connection, the award of medical expenses, and temporary total disability benefits. However, the Commission modifies the award of 100 weeks of permanent partial disability benefits representing loss of 20% of the person-as-whole in 13 WC 16557.

Findings of Fact & Conclusions of Law

1. Petitioner testified on February 16, 2013, she was working for Respondent, a mental health facility. On that day, a client was damaging a washroom and attacked another staff member. She, along with a third staff member, tried to restrain him. The floor was very slippery from soap from the dispenser the client broke. He was wedged between the handicap rail and the toilet and was trying to bite Petitioner, as she was trying to pull him away from the staff member he was attacking.

2. As the day went on her lower back started hurting. A little later, her head and neck began hurting as well. As the day progressed, so did her pain. At about 7 P.M., her supervisor advised her to go an emergency department. After the emergency department visit, Petitioner followed up with Dr. Luchici on February 19th. She related the incident and complained of pain in her neck and back.

3. Petitioner had a cervical MRI on March 13, 2014 and was then referred to Dr. Alexander, whom she saw on May 9, 2014. She complained of headache, left ear pressure, neck pain, decreased range of motion, dizziness, and left arm weakness. He did not think she was a surgical candidate and prescribed physical therapy, cervical traction, and placed her on light duty; she was basically working light duty since.

4. Petitioner also continued to treat with Dr. Luchici for severe headaches. She had sound/light sensitivity, nausea, and vomiting. She never had headache like that before. Petitioner had an injection in her neck on October 3, 2013. She continued to treat with Dr. Luchici for headache, upper arm weakness, and "dropping things."

5. Petitioner also treated with Dr. Dela Cruz. They discussed Botox injections, but he recommended an EMG/NCV first. The findings were consistent with C-8 radiculopathy. He then ordered a brain MRI. He prescribed medication to help the headaches. He referred her to the Pain Center. There, she treated with Dr. Rosche who ordered cervical epidural steroid injections.

6. In July she had her first Botox injection with Dr. Dela Cruz. As a result, the frequency of her migraine was reduced dramatically. She kept a log of her headaches. The more she received "Botox, the more those have backed off." She received several injections from Dr. Dela Cruz. She last saw him on January 17th and was scheduled to see him again in August of 2017. Dr. Dela Cruz indicated that basically she would be getting these injections for the rest of her life.

7. Petitioner also testified that Dr. Luchici put permanent restrictions on her that made her unable to work as a mental health tech. She entered a State program called Reasonable Accommodation and she became a rehabilitation case coordinator. In that job, she earned the same as she did as mental health tech 2, which she was at the time of her two previous accidents, but not as much as she did as mental health tech 3, which she was at the time of the third and instant accident. Petitioner no longer works for the State of Illinois, but in a gastro-enterology office working with insurance claims. She earns "considerably less" in that job than she did as a mental health tech 2. Petitioner plans to continue her Botox therapy with Dr. Dela Cruz.

8. Petitioner acknowledged that about two years previously, she had issues with her neck and back. She had "sciatica a couple of different times" because she has a weak core and a bulging disc. She had prior physical therapy for sciatica. She was not in treatment and was working full duty at the time of this accident. At that time, she noticed nothing about her neck or back.

9. Petitioner also testified she hurt her neck in October of 2010, when she slipped on a wet tiled floor while attending to a client coming out of a shower. She did not report that accident, and simply had treatment through her regular insurance. She had an MRI and a cortisone injection at that time. She was fine after that.

10. Petitioner also testified that currently she had slight pain in her neck and a little headache, but definitely not a migraine, and her "arm really doesn't really hurt." She gets pressure in the back of her neck which causes headaches, and pressure on the left-side of her face, and left shoulder. Her muscles will spasm and her left arm tends to go numb. She still took four medications.

11. On cross examination, she no longer lives in Illinois and currently lived in Georgia; she moved for "personal reasons pretty much," but the Illinois climate affects her "headaches and stuff." No doctor has indicated that climate was a factor in her condition. Dr. Dela Cruz, recommended she find a doctor locally, but she did not "want to go back to ground zero" with a new neurologist. Her last cervical injection was on December 24, 2014. She was continuing to treat with Dr. Dela Cruz for her arm with medication.

12. On redirect examination, Petitioner testified she continues to treat with Dr. Cruz who prescribes medication for her arm, neck, and headaches. The Botox is only for treatment of her migraines.

13. The medical records show that on October 3, 2013, Petitioner presented to Dr. Ibarra on referral from Dr. Luchici, for chronic neck pain since her accident on February 16th. After reading the MRI and his examination, Dr. Ibarra thought the majority of her headache and ear pressure was coming from impingement of the facet joints C2-C5 and the numbness/tingling from intermittent impingement of the thecal sac at C6-7. He offered her injection C2-C5. He administered an injection at C2-3.

14. On May 9, 2014, Petitioner presented to Dr. Alexander on referral from Dr. Luchici. She complained of headaches, neck pain, decreased range of motion, dizziness, intermittent left arm numbness/weakness, and left ear pressure. He related the MRI results. He recommended conservative treatment of physical therapy and traction and possible future epidural steroid injections.

15. Dr. Dela Cruz testified by deposition on March 24, 2017. He is board certified in general neurology. He first saw Petitioner for consultation on August 31, 2014 and performed an EMG on her. The EMG showed cervical radiculopathy. Petitioner also reported numbness/tingling and headache. Her MRI showed some arthritis and narrowing, which was not uncommon for a person of her age. Dr. Dela Cruz diagnosed migraine, moderate cervical radiculitis, and possible whiplash.

16. Dr. Dela Cruz reviewed the records of Dr. Luchici. He opined that the injuries Petitioner sustained triggered her current condition of migraine. He based that opinion on her lack of headache prior to the accident. He acknowledged that she had previous complaints regarding the neck and arm, but she had a lot more complaints of headache after the accident. Her prior condition did not change his causation opinion. He ordered an MRI of Petitioner's brain which was normal. That fact, also did not change Dr. Dela Cruz' causation opinion.

17. Dr. Dela Cruz also testified that he continued to provide Petitioner with periodic Botox injection therapy. He opined that Botox injections should be administered about every three months, depending on her symptomology. She should also continue her current medication regimen. If such treatment was not continued, there was a risk that her headaches could become more frequent.

18. On cross examination, Dr. Dela Cruz testified that migraine was the only condition he was treating Petitioner for. He agreed that on June 9, 2015, he noted that Petitioner reported she had headaches for at least two years. Headache symptoms associated with a whiplash injury would occur at the time of, or soon after, the injury.

In 13 WC 15667, the Arbitrator awarded Petitioner 100 weeks of permanent partial disability benefits representing loss of 20% of the person-as-a-whole. In assessing the statutory criteria in determining permanent partial disability benefits, the Arbitrator gave weight to her age, 45, which meant she would deal with her disability for a considerable remaining work life, she gave some weight to Petitioner testimony that she earned considerably less than she did at the time of the accident, she also gave weight to her reported breakthrough migraines and her need for prospective treatment.

In our analysis of the record, the Commission notes that it is unclear to what extent, if any, her instant accident permanently aggravated her spinal condition. Petitioner acknowledged previous sciatica and a cervical condition, for which she received significant treatment prior to the instant accident. In addition, Dr. Dela Cruz agreed that Petitioner had prior neck and back complaints prior to the accident and opined that her headaches were triggered by her accident. Finally, it appears that Petitioner last received treatment related to her spinal condition in 2014.

18IWCC0184

The Commission also notes that the Arbitrator may have overestimated Petitioner's loss of earning potential. While she testified that she earned considerably less in her current job than she did at the time of the accident, she did not quantify that difference. In addition, after she was precluded from returning to her mental health tech job, Respondent accommodated her restrictions and placed in her in a job in which she earned the same as she did as a mental health tech 2, which she testified was "considerably" more than she earns in her current job. Presumably, she would still be receiving the salary of a mental health tech 2, if she remained in Respondent's employ and not voluntarily relocated to Georgia, "personal reasons pretty much," Finally, it appears that Petitioner's migraine condition improved considerably with Botox therapy. While, she apparently will need prospective therapy, there is no reason to believe that continued therapy would not continue to mitigate her migraine symptoms in the future.

In looking at the record as a whole, the Commission finds than a permanent partial disability award of 75 weeks, representing loss of 15% of the person-as-a-whole, is appropriate in this claim and modifies the decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $697.42 per week for a period of 37&1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act, less credit of $3,693.82 paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $627.68 per week for a period of 75 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the loss of 15% of the person-as-a-whole

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for medical expenses incurred through December 1, 2014 for her left arm/neck condition and through the date of arbitration, July 27, 2017 for her migraine condition, under §8(a) of the Act pursuant to the applicable 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.

DATED: MAR 23 2018

Deborah L. Simpson

David L. Moore

Stephen J. Mathis

DLS/dw
O-3/8/18
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0184

FELZ, JUDY A
Employee/Petitioner

Case# **13WC016557**

13WC016555
13WC016556

SOI-JACK MABLEY DEVELOPMENTAL CENTER
Employer/Respondent

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:

0021 REESE & REESE
TODD S REESE
979 N MAIN ST
ROCKFORD, IL 61103

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

6066 ASSISTANT ATTORNEY GENERAL
BRETT KOLDITZ
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

AUG 29 2017

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

18IWCC0184

STATE OF ILLINOIS)
)SS.
COUNTY OF
LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Judy A. Felz
Employee/Petitioner

v.

Case # **13** WC **16557**

Consolidated cases: 13 WC 16555
13 WC 16556

State of Illinois – Jack Mabley Developmental Center
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Ottawa**, on **July 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? (liability only)

K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD (liability only)
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **2/16/13**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner earned **$54,398.76**; the average weekly wage was **$1,046.13**.

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

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

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

Respondent shall be given a credit of **$3,693.82** 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 credit for medical bills paid through its group medical plan, under Section 8(j) of the Act.

ORDER

Petitioner was temporary and totally disabled from 9/17/13 through 12/7/14. The parties have stipulated that Petitioner received full TTD benefits, without over/underpayments, from 9/17/13 through 1/31/14 and 4/1/14 through 5/20/14. Respondent shall pay Petitioner temporary total disability benefits of $697.42/week for 37-1/7weeks, commencing 2/1/14 through 3/31/14 and 5/21/14 through 12/7/14, as provided in Section 8(b) of the Act, less credit for $3,693.82 paid.

Respondent shall pay Petitioner temporary partial disability benefits of $3,374.36, for the period of 2/17/13 through 9/16/13, as provided in Section 8(a) of the Act. ARB EX 3- as stipulated

Respondent shall pay reasonable and necessary medical services incurred in connection with Petitioner's migraine condition through trial on 7/27/17 and through 12/1/14 for her left arm and neck condition pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts paid, including amounts paid for which credit is given under Section 8(j) and will hold Petitioner harmless for same.

Respondent shall pay Petitioner permanent partial disability benefits of $627.68/week for 100 weeks, because the injuries sustained caused the 20% 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.

Carolyn M. Doherty

Signature of Arbitrator

8/24/17

Date

AUG 29 2017

FINDINGS OF FACT

In case 13 WC 16557, it is undisputed that Petitioner sustained a work related accident on 2/16/13. On this date, Petitioner was performing her normal duties as a mental health tech 2 while training to become a mental health tech 3. It is undisputed that on 2/16/13, Petitioner was working overtime on her shift when a patient started to "act up." Petitioner went to assist a co-worker who was trying to restrain the patient in a bathroom. Petitioner went into the bathroom and began wrestling with the patient to remove his hands from the co-worker. The patient also began to attack Petitioner.

Petitioner testified that she returned to work after the altercation but throughout the shift she began to experience pain in her low back, left arm, left shoulder and neck pain. Petitioner went to the occupational health clinic at KSB Hospital after finishing her shift. At the clinic, she complained of low back pain following the altercation with a patient that day. The records note that Petitioner reported "I've had problems with sciatica in the past and I just don't want to go through that again." PX 12. Petitioner testified to having prior neck and low back problems due to "bulging disks" for which she underwent physical therapy in 2010. Petitioner received a cortisone injection in her neck from Dr. Soriano in 2010 as well. Petitioner testified that she was not under treatment for her neck or her low back at the time of the accident in 2013 and was working full duty. Petitioner was discharged from the ER with a diagnosis of sciatic and told to follow up with Dr. Luchici at CGH Medical Center.

On 2/19/13, Petitioner continued to have pain in her low back, but was also noticing neck pain. She presented to Dr. Danca Luchici at CGH Medical Center. (PX 13). She complained of neck and low back pain after the work accident on 2/16/13 and that she was also experiencing numbness and tingling in the left arm. She described the incident she had been involved in. The medical records also refer to an incident that happened two years prior in which she saw Dr. Soriano and had an abnormal MRI after an injury to her neck with radiation to her left arm. She had some physical therapy and here conditions improved. On examination, she was tender over the low cervical spine about C5 and C6. She was also tender over the lumbar spine at the L4-5 level. The assessment was that she had neck pain with left upper extremity neuropathy. Dr. Luchici ordered an MRI of the cervical spine, prescribed Flexeril and told to continue the ultram and add Motrin 400mg three times per day. She was also given a prescription for physical therapy and a referral to Dr. Soriano.

On 3/14/13, the MRI of the cervical spine was obtained and noted mild multi-level central canal and foraminal stenosis. PX 14. Petitioner was able to be seen by Dr. Todd Alexander, a neurological surgeon, on 5/9/13. (PX 15). Petitioner testified and the medical records reflect that she had complaints of headaches, left ear pressure, neck pain, decreased range of motion, dizziness and left arm numbness and weakness that was intermittent. She related that these symptoms came on after the work accident on 2/16/13. She also advised Dr. Alexander that she did have an incident back in 2010 and she had received an epidural steroid injection in the neck. On examination, she had some mild decreased sensation over the left radial forearm and first webspace in the hand. Dr. Alexander reviewed the MRI from 3/14/13, which demonstrated at C4-5 there was mild disc protrusion with some minimal encroachment on the canal. At C5-6 there was a broad-based disc and osteophyte complex with some mild bilateral neuroforaminal narrowing. Dr. Alexander's impression was that she had neck pain and some cervical radicular symptoms that were aggravated from the altercation at work with the mental health patient. He noted no myelopathy or significant radiculopathy on exam. Dr. Alexander recommended conservative treatment with physical therapy and cervical traction and referred her for therapy. If she continued to have worsening symptoms, then another epidural steroid injection would be considered. Petitioner was work light duty and started physical therapy on 6/5/13. (PX 13).

On 6/26/13, Petitioner was seen by Dr. Luchici. She complained of severe headache and that she had to miss work the day before. She indicated that she started having the headaches and neck pain after the work accident on 2/16/13. Examination of the cervical spine revealed tenderness over the left trapezius and lower cervical spine. She was advised to continue the current medications, but also added cyclobenzaprine at night. She continued regular follow up visits with Dr. Luchici and physical therapy. Dr. Luchici had referred Petitioner to a pain clinic and they were awaiting authorization. On 7/22/13, Dr. Luchici noted that Petitioner continued to have reoccurring headaches with nausea, vertigo and neck pain since the work accident. Dr. Luchici indicated that the head and neck pain were secondary to the work related injury in February.

On 10/3/13, Petitioner was able to be seen by Dr. Juan Ibarra at CGH Medical Center. (PX 16). Petitioner testified and the medical records reflect that she had chronic neck pain that had been ongoing since February when she was involved in the altercation at work. She was sent to Dr. Ibarra because of the chronic headaches, left ear pressure, neck pain and decreased range of motion of her neck whenever she laterally rotated her head from side to side. On examination, Dr. Ibarra noted that there was an on and off left upper extremity numbness and tingling that goes all the way down to the left hand. The MRI of the cervical spine from March was reviewed and showed some osteophyte disk complexes impinging slightly on the thecal sac at C5-6 and C6-7. There were areas of facet or hypertrophic changes that Dr. Ibarra appreciated at C2-3 and C3-4 bilaterally. Dr. Ibarra diagnosed Petitioner with chronic neck pain secondary to left cervical facet syndrome and diskogenic protrusions at C5-6 and C6-7. Dr. Ibarra felt that the majority of her pain was coming from impingement of the medial branches of the left C2-3, C3-4, C4-5 facet joints. This was, in his opinion, what was causing the headaches and left ear pressure with decreased range of motion. Dr. Ibarra recommended and attempted to perform an injection of the medial branch of the C2-3 facet joint. However, Petitioner was unable to tolerate the procedure and it was not performed. Petitioner was off work since 9/17/13.

Petitioner continued to have neck pain, bilateral temporal headaches and occipital left and in addition she had developed a poor grip on the left with numbness in the left fourth and fifth fingers. She continued to follow up with Dr. Luchici and on 2/21/14 was given another referral to Dr. Alexander.

The Respondent then scheduled Petitioner to attend a Section 12 examination with Dr. Patrick O'Leary. On 4/24/14, Petitioner attended the examination with Dr. O'Leary. (RX 1). Dr. O'Leary related a cervical strain to the work accident, but indicated she had reached MMI, that she needed no further treatment and she could return to work without restrictions. He noted that the left arm pain was "difficult to explain from a cervical etiology." He attributed the left arm symptoms to unrelated cubital tunnel ulnar nerve entrapment at the left elbow and carpal tunnel at the left wrist. Petitioner continued to experience symptoms she had been experiencing and returned to Dr. Luchici for further treatment.

On 5/20/14, Petitioner was able to be seen by Dr. Luchici. She had continued complaints of weakness in the left upper extremity, neck pain and headaches. Dr. Luchici noted that on exam he did not objectively find any weakness in the left upper extremity grasp, push and pull. PX 13. On 6/19/14, Dr. Luchici noted chronic headaches and referred Petitioner to Dr. Dela Cruz for botox injections. He also ordered nerve conduction studies for the left upper extremity. She was also referred for counseling due to anxiety over her condition. PX 13. The EMG of the left upper extremity done on 7/1/14 revealed C8 radiculopathy. PX 19.

On 7/31/14, Petitioner testified and the medical records reflect that she presented to Dr. Chester Dela Cruz's office at CGH Medical Center for initial paperwork and preliminary examination. (PX 13). She described continual headaches, neck pain and left upper extremity pain with some tingling sensation on the fourth and fifth fingers of the left hand. On examination, she had a positive Tinel's and Phalen's test on the left with

numbness in the fourth and fifth fingers. Her assessment indicated chronic headaches and she was to see Dr. Dela Cruz for possible Botox injections. She was also assessed with cervical radiculitis at c-8 per the EMG. A brain MRI was ordered which was performed with normal results.

Petitioner testified that she did previously have treatment prior to the work accident on 2/16/13 that involved a headache on two occasions. There are two dates of service that reference a headache and a migraine. Petitioner testified that her previous headache symptoms were in no way similar to the migraines she was currently experiencing. She testified that what she may have thought was a migraine previously was nothing but a minor headache. She did not have continual headaches or migraines like she was having since the work accident on 2/16/13.

On 9/5/14, Petitioner followed up with Dr. Dela Cruz. The results of the brain MRI were reviewed and the study was unremarkable for any delayed hemorrhages or any masses or tumor. She continued to complain of daily headaches that were constant, pressure, achy and usually on the left side of the neck, base of the skull and temporofrontal region with intensity of moderate to severe per migraine diary. She had tried Topamax with no relief and reported that she tried the Sumatriptan nasal spray and that helped for about 20 minutes. She was currently taking Gabapentin that had been prescribed by Dr. Luchici, who she continued to follow up with, and she reported that the medication at times helped her go to sleep and lessened the pain in her neck. It was also noted that she had a trial facet injection with Dr. Ibarra last year, but due to technical difficulty it was not completed and she had not been back since the procedure was too painful to continue. She was continued on her prescribed medications and advised to follow up in one month.

On 10/3/14, Petitioner returned to Dr. Dela Cruz. It was noted that her dosage of Topamax had been increased to 25mg 2 tablets at bedtime and Gabapentin was increased to 100mg two capsules and Nortriptyline was added at bedtime. She reported that she felt 25% better. Her headaches recurred daily usually bitemporal, paracervial with pressure and stabbing character and an intensity of 2-5/10. Medications were continued and Petitioner was to follow up in 2 months. PX 13.

On 10/30/14, Petitioner presented to Dr. Anatoly Rozman at Rockford Medical Rehabilitation. (PX 18). She had been referred by Dr. Luchici for the neck pain that radiated to the left arm with weakness. Her treatment history and diagnostic studies were reviewed. On examination, it was noted that she had mild weakness in the left upper extremity with positive Spurling's maneuver and positive Hoffman's test. She had decreased sensation in the distribution of the C7 on the left side. She also had pain to palpation in the cervical paraspinal muscles on the left side without any significant swelling. Dr. Rozman's impression was cervical disc disease with cervical radiculopathy and carpal tunnel syndrome and anxiety. Petitioner was referred to Dr. Rosche in Rockford for epidural injections and advised to continue on her current medications.

On 11/17/14, Petitioner was seen by Dr. A.P. Rosche at Advanced Pain Intervention. (PX 19). She was being seen at the request of Dr. Rozman for her complaints of left neck and head pain. She indicated that her pain started in 2013 and continued to the present. She characterized this as aching, throbbing, sharp and stabbing; worse with bending, lifting and twisting; improved with lying supine and resting. This causes moody irritability, decreased sleep quality, difficulty concentrating, and decreased physical capacities. Physical traction has provided very little benefit. She does take some gabapentin and noritriptyline with some benefit of pain in the left neck. She also complained of intermittent numbness in the left arm. Dr. Rosche reviewed the EMG and MRI's that had been completed. After examination, Dr. Rosche recommended and proceeded with a cervical epidural steroid injection at C6-7.

Per Dr. Luchici, Petitioner was off work but applying for alternative work with the Respondent. PX 13. On 11/17/14, Dr. Luchici returned Petitioner to work with restrictions of no lifting more than 10 pounds above waist level and no pushing or pulling. PX 45. Petitioner eventually was placed in an alternative job with Respondent and began the new job on 12/8/14.

On 11/21/14, Petitioner followed up with Dr. Dela Cruz. She noted that after the recent injection with Dr. Rosche she had about 50% reduction of neck pain and her headaches had also decreased by approximately 50%. Her headaches that used to be every day were down to twenty-three days in October and fifteen days of the month in November. Her headaches were mostly left sided and frontal, pressure, sharp throbbing intensity and photo/phonophobia with nausea but no vomiting. She reported that the nasal spray had also helped her headaches. Dr. Dela Cruz increased the Topamax dosage to see whether that would afford her better headache control. A 3 month follow up was advised. PX 13.

On 12/1/14, Petitioner returned to Dr. Rosche for follow up and further injections. She indicated that the cervical epidural injection had given her about 70% pain relief during the first week and 50% overall improvement of her cervical and upper extremity symptoms. Dr. Rosche noted that her underlying diagnosis included discopathy at multiple levels in the cervical spine, as well as occipital and facet-related symptoms. He indicated that she appeared to have a mixed cervical radicular and cervicogenic syndrome, indicating facet arthropathy, myofascial dysfunction and discopathy with some spasm. Dr. Rosche believed it would be in her best interest to consider facet therapy based on her pain distribution. Dr. Rosche proceeded with facet joint injections at the C1-2 and C2-3 levels. Petitioner followed up with Dr. Rozman on 12/24/14 and was continued on her same prescriptions and treatment plan with Dr. Dela Cruz.

On 3/9/15, Petitioner was next seen by Dr. Dela Cruz. She continued to have complains of neck pain, left shoulder area pain and headaches and pressure in her face and ear. The history of her headaches was reviewed and it was also noted that she was using a TENS unit for the neck pain. The medications were helping her conditions, but Dr. Dela Cruz discussed the option of using Botox injections for the chronic migraines she was having if she did not respond to the new trial dosages of medication. He recommended that she split her dosages up between morning and evening and increase her Nortriptyline. She continued to follow up with Dr. Dela Cruz on a regular basis until she was seen on 7/29/15 when she received her first Botox injection treatment.

On 7/29/15, Petitioner received her first Botox injection treatment with Dr. Dela Cruz. It was noted that her headaches remained daily, usually having a pressure, aching and sharp character and were bioccipital/bitemporal lasting thirty minutes to the whole day. She did report that the intensity of the headaches had decreased with the current combination of Topamax and Nortriptyline, but she was reporting a feeling or tiredness with Nortriptyline. Dr. Dela Cruz proceeded with a Botox injection. Petitioner continued with regular follow up visits with Dr. Dela Cruz every 3 months for repeat Botox injections up until the time of trial. The last injection was received on 5/12/17 and she was then scheduled for follow up and Botox injection in August of 2017.

Petitioner testified that her next appointment with Dr. Dela Cruz is scheduled in August for another Botox injection. Petitioner testified that she has been advised that her condition is permanent and that she will need ongoing prescription medication and Botox injections. Petitioner testified that she wishes to continue with the maintenance treatment as prescribed and recommended by Dr. Dela Cruz. Petitioner testified that she has since moved to Georgia where she currently resides.

Respondent offered into evidence the report of Dr. Patrick T. O'Leary. (RX 1). Dr. O'Leary took a history, reviewed the treatment records and examined Petitioner. The history revealed that she was injured at work on

2/16/13. She was assisting a fellow colleague in restraining an unruly patient. The patient was known to escalate in the past and the patient was becoming very combative in a closed small room and Petitioner and one other colleague attempted to help her colleague who was being accosted by this patient. She described during that time a wrenching motion to her neck and back. At the time of the examination, Petitioner complained of aching and burning in the back of her head and the left side of her neck. She also circled her entire left arm, but mainly the thumb and then the ulnar border digits and an area on the radial forearm and an area underneath her inner axilla. She indicated numbness exists mainly, and weakness in the small finger and ring finger and in the thumb. On examination, he noted that the cervical spine revealed mild left paracentral tenderness. Looking upward, her cervical extension gave subjective pain. Looking downward, her cervical flexion did not cause as much pain. Looking to the left was limited. She had reasonable range of motion of both shoulders and impingement signs were negative. She did have a positive elbow flexion test which reproduced symptoms in her left arm and small finger and ring finger. Dr. O'Leary opined that she did suffer a cervical strain as a result of the work accident on 2/16/13. He indicated that the left arm pain was difficult to explain from a cervical etiology and believed it was more related to possibly cubital tunnel or ulnar nerve entrapment at the left elbow, as well as carpal tunnel syndrome which is entrapment at the left wrist. He opined that the objective findings based on the mild degree of degenerative change in her cervical spine MRI can fit with a persistent neck pain. He also indicated that the arm weakness and numbness fits more with the peripheral compressive neuropathy. Dr. O'Leary found that she still had some persistent symptoms. He felt that it was reasonable that initially at the time of the work accident she would not have complained of neck pain and that it is possible that a few days later it may have started. His diagnoses was cervicalgia or neck pain and left upper extremity pain and weakness, which he believes is more related to peripheral compressive neuropathy and not work related. He opined that she was MMI, needed no further diagnostic studies or treatment and that she could return to work without restrictions.

Petitioner presented the evidence deposition of Dr. Chester Dela Cruz. (PX 46). Dr. Dela Cruz is board certified in neurology. Dr. Dela Cruz began treating Petitioner for her Migraine headaches on 7/1/14 and continues to provide maintenance treatment in the form of Botox injections and prescription medication. He testified that he had reviewed all of Petitioner's treatment records as a result of this work accident. Dr. Dela Cruz opines that Petitioner's diagnoses are numbness in the left arm, neuropathy in the left arm, chronic migraine headaches and whiplash. He opines that those conditions are related to the work accident on 2/16/13. (pp. 11, 29-31). He opined that the EMG obtained on 7/1/14 is consistent with C8 radiculopathy. Dr. Dela Cruz opines that Petitioner is at the best he can make her at this point, but that she needs continued prescriptions of Topamax, nortriptyline, Sumatriptan nasal spray and ongoing Botox injections every 3-6 months. The Topamax and nortiptyline are daily preventative medications for the migraine headaches and the nasal spray is for those times that she has breakthrough migraines. The Botox injections are needed to reduce the frequency of migraines and hopefully Petitioner will be able to go longer periods in between injections as she continues with this treatment. Dr. Dela Cruz testified that if she were to stop the Botox and prescription medications, then the migraine headaches would return to a more frequent timeframe. Dr. Dela Cruz relates all of the treatment and the recommended ongoing maintenance treatment to the work accident on 2/16/13 based primarily on the fact that Petitioner had no prior history of chronic migraine headaches. PX 46.

Petitioner testified as to what she currently notices about herself. She testified that she was unable to return to work as a Mental Tech II or III and she entered into a program with the Respondent to find an alternative job placement. In December of 2014, she was placed into a job as a vocational rehabilitation case coordinator at the same rate of pay she was receiving. She testified that due to family issues she had to relocate out of state and look for further alternative work within her restrictions. She was able to find employment with a doctor's office in a secretarial type of position. Her duties include secretarial work, scheduling appointments, filing, and other duties associated with office work

Petitioner further testified that she continues to have neck pain and headaches/migraines along with weakness in her left arm. She notices pressure in the back of her neck, especially on the left side, along with pressure/pain in her teeth and ear on the left side. She continues to experience pain in her left shoulder/neck area and muscle spasms after extensive work duties and also experiences left arm numbness. She continues with the three prescription medications (Topamax, Nortriptyline and Sumatriptan nasal spray) that have been prescribed by Dr. Dela Cruz. She testified that her restrictions have become permanent and she continues under those same restrictions for all activities of daily living and work. She testified that she has always planned on and would like to work until the remainder of her statistical work life. She also testified that she has been forced to miss work due to migraine headaches and it is approximately 2-3 days per month that she misses because of the migraine headaches. Finally, Petitioner testified that she wishes to continue with the Botox injections and prescription medication that Dr. Dela Cruz has recommended and prescribed.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

With respect to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

The Arbitrator notes that accident is not in dispute. Based on the record in its entirety, the Arbitrator finds causal connection for Petitioner's current complaints of migraine headaches through the date of trial. The Arbitrator finds causal connection for Petitioner's neck and left arm complaints through 12/1/14, the date of her last treatment with Dr. Rosche. Shortly before that date, Dr. Luchici had released Petitioner to work with restrictions as of 11/17/14.

In so finding, the Arbitrator notes Petitioner's testimony regarding her continued and consistent complaints of migraine headaches which are buttressed by the continued treating medical records. The Arbitrator further notes that Petitioner continues to treat for her migraine headaches on a maintenance basis but does not currently treat for her neck or left arm complaints. The Arbitrator further relies on the medical records documenting the continued condition of migraine headaches and the persuasive testimony of treating physician Dr. Dela Cruz who opined that Petitioner's migraine headaches are causally related to her work accident. Dr. O'Leary did not opine with regard to Petitioner's migraine headaches.

With regard to the left arm and neck complaints, the Arbitrator relies on the treating medical records in finding causal connection for Petitioner's neck and left arm complaints through 12/1/14, the date of her last visit with Dr. Rosche. Per Dr. Luchici, Petitioner was off work but applying for alternative work with the Respondent. PX 13. On 11/17/14, Dr. Luchici returned Petitioner to work with restrictions of no lifting more than 10 pounds above waist level and no pushing or pulling. PX 45. Petitioner found an accommodated position thereafter in December 2014. Accordingly, the Arbitrator finds that Petitioner's condition of ill-being in her neck and left arm is causally related through 12/1/14.

With respect to issue (J), whether Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator finds that Respondent shall pay Petitioner's reasonable and necessary medical expenses incurred in connection with the treatment of her

migraine headaches through the date of trial, 7/27/17, pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent receives credit pursuant to Section 8(j) of the Act.

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator finds that Respondent shall pay Petitioner's reasonable and necessary medical expenses incurred in connection with the treatment of her neck and left arm symptoms through 12/1/14 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent receives credit pursuant to Section 8(j) of the Act.

With respect to issue (K), what temporary benefits are in dispute (TTD based on liability), the Arbitrator finds as follows:

The parties have stipulated that Petitioner received full TTD benefits, without over/underpayments, from 9/17/13 through 1/31/14 and 4/1/14 through 5/20/14 based on a contractual agreement. ARB EX 3.

The parties have stipulated that Respondent has paid TTD benefits in the amount of $3,693.82 for the period of 2/1/14 through 3/31/14. The Arbitrator finds that Respondent shall receive a credit in the amount of $3,693.82 for the TTD period of 2/1/14 through 3/31/14.

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent shall pay Petitioner temporary total disability benefits of $697.42/week for 37-1/7weeks, commencing 2/1/14 through 3/31/14 and 5/21/14 through 12/7/14, as provided in Section 8(b) of the Act, less credit for $3,693.82 paid.

With respect to issue (L), the nature and extent of the injuries, the Arbitrator finds as follows:

In considering permanent disability in this matter, the Arbitrator shall base the determination on the following factors pursuant to Section 8.1(b) of the Act: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single factor shall be the sole determinant of disability. 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 are explained below. The Arbitrator initially notes that no reported level of impairment pursuant to Section 8.1b(a) was provided. The remaining enumerated factors were considered as follows.

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

With regard to subsection (ii) of Section 8.1(b), the occupation of the employee, the Arbitrator notes that Petitioner no longer works for the Respondent dealing with the mentally and physically handicapped adults. Petitioner was unable to continue working as a Mental Health Tech III for Respondent due to her permanent restrictions. Petitioner sought alternative employment with Respondent and was able to be placed into an alternative job position with Respondent as a vocational rehabilitation case coordinator. Respondent continued Petitioner's wages at the same rate. Petitioner then left that employment for personal reasons and now lives out-

of-state and works for a doctor's office. Her duties include secretarial work, scheduling appointments, filing, and other duties associated with office work. Therefore, the Arbitrator gives some weight to this factor.

With regard to subsection (iii) of Section 8.1(b), the age of the employee at the time of the injury, the Arbitrator notes that Petitioner was 45 years old at the time of the accident. Petitioner has an extended period of work life remaining and will have to deal with the residual effects of the ongoing migraine headaches, continued use of prescription medication and the ongoing Botox injections. Petitioner also testified that she continues to have to use personal sick days for break-through migraine headaches that prohibit her from working. Petitioner testified that she experiences these break-through migraines one to two times a month. The Arbitrator gives some weight to this factor.

With regard to subsection (iv) of Section 8.1(b), petitioner's future earnings capacity, the Arbitrator notes that Petitioner continues on prescription medication and regular Botox injections for her migraine headaches. Petitioner was unable to return to work in the position she was hired because of her permanent restrictions and she was originally placed in an alternative job with the Respondent. The Arbitrator understands that Petitioner left that employment and now lives out-of-state and works in a doctor's office doing mostly secretarial work. Petitioner testified that she earns considerably less than what she was able to earn in the full performance of her job at the time of her accident. The Arbitrator gives some weight to this factor.

With regard to subsection (v) of Section 8.1(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained injuries to her neck and left upper extremity and that she suffers from ongoing migraine headaches for which she requires maintenance treatment. Petitioner has not treated for her left arm or neck complaints for several years. The Arbitrator finds that the evidence of disability is corroborated by the treating medical records and gives some weight to this factor.

Giving equal weight to all factors, the Arbitrator finds that Petitioner sustained 20% loss of use of the person 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

PATRICK ZWEIGART,

Petitioner,

vs. NO: 11 WC 13018

MENARD CORRECTIONAL CENTER,

Respondent.

18IWCC0185

DECISION AND OPINION ON REVIEW under SECTION 19(h) and 8(a)

Timely Petition for Review under Section 19(h) and Section 8(a) of the Act having been filed by Petitioner herein and notice given to all parties, the Commission, after considering Petitioner's claim that his disability has increased and being advised of the facts and law, finds Petitioner failed to prove that his disability has increased subsequent to April 16, 2013.

The Petition for Review filed by Petitioner on May 6, 2015, provides little guidance with respect to his claim, indicating only, "Prospective medical care is necessitated by the deterioration of [his] physical condition." Attached to the Petition for Review were both the controlling Arbitration Decision, dated May 16, 2013, and the controlling Decision and Opinion on Review, dated December 11, 2013.

The Arbitration Decision contained a "Statement of Facts" that discussed Petitioner's low back and right knee. The Arbitration Decision's "Opinion and Order" addressed only Petitioner's low back and only awarded benefits under Section 8(d)2 of the Act for the injuries sustained to Petitioner's low back. The Arbitration Decision made no finding of any causal relationship between the complaints involving Petitioner's right knee and the January 6, 2010, lifting incident that injured Petitioner's low back. The Commission Decision and Opinion on Review

unanimously affirmed and adopted the Arbitration Decision.

A hearing pursuant to Petitioner's Petition for Review was held on September 6, 2017, and was presided over by Commissioner Deborah Simpson. Before Commissioner Simpson, Petitioner testified that the Arbitration Decision accurately reflected the injuries he sustained to his low back and right knee as well as the care and treatment that he received relative to his right knee

Revisiting the Arbitration Decision, the Commission finds Petitioner's right knee is discussed in one paragraph, a paragraph that includes a sentence about Petitioner complaining of having some complaints in the right knee that he attributed to his January 6, 2010, accident, and also a notation by Dr. Paletta on September 14, 2011, that the symptoms found in Petitioner's right knee were likely prompted by favoring one leg due to the back injury. Again, neither the presiding arbitrator nor the Commission endorsed Dr. Paletta's causation opinion.

The Commission finds the Petition under Section 19(h) and Section 8(a), specifically Petitioner's claim that his right knee has worsened since the time of the original arbitration hearing, to be a backdoor appeal of the Arbitration Decision. That finding notwithstanding, Petitioner offers no compelling evidence to relate his complaints of right knee pain to his January 6, 2010, accident. More significantly, Petitioner offers no compelling evidence that his right knee has worsened since the arbitration hearing.

At the conclusion of the hearing before Commissioner Simpson, Petitioner tendered several examination records into evidence. Several of these records focus exclusively on Petitioner's complaints of low back pain and make no reference concerning Petitioner's right knee. The Patient Visit Note authored by Dr. Philip Chu on August 21, 2013, indicated Petitioner presented for evaluation of back pain. The Review of Systems on that visit noted no muscle aches, no localized soft tissue swelling, no localized joint swelling, and no localized joint stiffness. The only positive complaint recorded under the Review of Systems was of lumbago. Dr. Chu's physical examination resulted in no mention of Petitioner's right knee being examined but did note that Petitioner's motor strength was normal. Petitioner was seen by Dr. Matthew Gornet on March 6, 2014, and again on January 26, 2015. On both occasions, neither Petitioner's complained-of symptoms nor Dr. Gornet's examination involved Petitioner's right knee. Of the records tendered to Commissioner Simpson, these three records are closest in time to Petitioner's January 6, 2010, accident. Despite their focus on Petitioner's low back complaints, it is notable that neither Dr. Chu nor Dr. Gornet recorded Petitioner complaining of right knee pain or eliciting a painful response in Petitioner's right knee when he was seen by them.

Beginning with the July 27, 2015, examination note written by Dr. George Paletta, Petitioner's medical records begin to address complaints involving Petitioner's right knee. Dr. Paletta wrote that he had previously seen Petitioner for problems related to his right knee in 2011 and had diagnosed Petitioner with predominantly medial compartment degenerative disc disease. He then wrote of Petitioner's coming in on that day with increasing right knee pain. His examination of Petitioner on July 27, 2015, led him to conclude Petitioner suffered from end-

stage osteoarthritis in the right knee with mild valgus deformity and refer Petitioner to Dr. Helen Blake for a viscosupplementation injection.

Petitioner presented to Dr. Blake on October 25, 2015. He provided Dr. Blake with a detailed history about how his pain began and of Dr. Paletta's diagnosis of him experiencing end-stage osteoarthritis. Dr. Blake provided Petitioner with a viscosupplementation injection and discharged Petitioner from her care.

Petitioner next treated with Dr. Nathan Mall on June 23, 2017. He provided Dr. Mall with a history of injuring his back years earlier, an injury that caused him to walk abnormally. At the time he met with Dr. Mall, he indicated to believing that he put more pressure on his right knee. He also indicated to Dr. Mall that he had ongoing knee pain for some time. Dr. Mall examined Petitioner and diagnosed him as having tricompartmental osteoarthritis in both knees.

Of the three physicians with whom Petitioner treated his right knee, Dr. Paletta would have been the most obvious choice for Petitioner to have testify on his behalf. Dr. Paletta, by virtue of treating Petitioner's right knee in 2011 and again in 2015, would have been most-qualified to speak to the claimed worsening of Petitioner's right knee. Instead, Dr. Mall testified on Petitioner's behalf. Dr. Mall's testimony was not persuasive.

Dr. Mall testified to believing the condition that he found Petitioner in on June 23, 2017, was a continuation of Petitioner's prior pain but did not indicate that Petitioner's then-current condition was worse than it had been previously. Objectively, he indicated Petitioner had severe tricompartmental osteoarthritis in 2011 and was basically the same condition as has he had in 2016. The Commission interprets Dr. Mall's testimony as indicating that Petitioner's condition, regardless of compensability, has not worsened but had remained static over the years.

Petitioner's tendered medical records, rather than reflecting either steady or abrupt complaints of a worsening right knee, demonstrate that he experienced problems involving his right knee in 2011, 2015, and 2017 with no objective indication that those problems were worse in 2017 than in any of the years prior. Given the seemingly sporadic and fleeting nature of Petitioner's treatment, it appears the complaints made in 2011, 2015, and 2017 represented nothing more than flare ups of the osteoarthritis present in Petitioner's right knee.

Again, the Commission finds Petitioner's Petition under Section 19(h) and Section 8(a) of the Act to be an attempt to circumvent the Arbitration Decision and the Commission's Decision and Opinion on Review. Neither decision contemplated that Petitioner's right knee complaints were causally related to his compensable injury. The only avenue left for Petitioner to obtain compensation and/or treatment for his right knee under the Act was to claim that the compensable injury to his low back resulted in the symptomology in his right knee. The Commission finds Petitioner's testimony, his medical records, and the testimony of Dr. Mall do nothing to change its impression that only his low back was injured as a result of his January 6, 2010, lifting accident.

The Commission also concludes Petitioner's focusing on his right knee to the exclusion of his low back in advancing his claim under Section 19(h) and Section 8(a) indicates that his low back has not worsened since the time of the arbitration hearing.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Benefits under Section 19(h) and Section 8(a) of the Act is denied.

DATED: MAR 2 6 2018
KWL/mav
O: 02/06/18
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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Adolfo Torres,

Petitioner,

vs.

NO: 11 WC 936

18IWCC0186

Central Transport International,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 28, 2015, is hereby affirmed and adopted.

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

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

18IWCC0186

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

DATED: MAR 2 6 2018
TJT:yl
o 3/20/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TORRES, ADOLFO
Employee/Petitioner

Case# **11WC000936**

CENTRAL TRANSPORT INTERNATIONAL
Employer/Respondent

18IWCC0186

On 9/28/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0391 HEALY SCANLON LAW FIRM
JACK CANNON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

1682 HINSHAW & CULBERTSON
PETER H CARLSON
222 N LASALLE ST SUITE 300
CHICAGO, IL 60601

18IWCC0186

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

Adolfo Torres
Employee/Petitioner

v.

Central Transport International
Employer/Respondent

Case # **11** WC **00936**

Consolidated cases: _____

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

DISPUTED ISSUES

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

18IWCC0186

FINDINGS

On 2/22/2010, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $55,333.00 ; the average weekly wage was $1,064.11.

On the date of accident, Petitioner was 42 years of age, ***married*** with 2 dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$638.47/week** for **125 weeks**, because the injuries sustained caused the **25%** 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

9/25/15
Date

SEP 28 2015

18IWCC0186

FINDINGS OF FACT

Adolfo Torres ("Petitioner") testified that he worked for Central Transport International ("Respondent") as a truck driver and has been so employed for six years. His duties as a truck driver include driving for the city, dropping off and picking up cargo, moving cargo up to 200 pounds with a pallet jack and unloading truck trailers at terminals. He described loading cargo onto the pallet by getting the jack under the material, lifting then pulling the entire pallet jack.

On 2/22/10, Petitioner reported to work for Respondent. He testified he felt very well that morning and that his low back felt good. Prior to this date, Petitioner testified he injured his low back at work in July 2009, treated briefly was Concentra and was released to full duty in 2009. He stated he was working full duty leading up to 2/22/10. Between July 2009 and 2/22/10, he testified he had on and off pain but was able to work. On direct and cross, Petitioner acknowledged that his prior medical history is positive for prior low back injury occurring on 7/17/09 while working for Respondent. Px4:219. At that time, symptoms were positive for stiffness without radiation. He was diagnosed with lumbar strain and give light duty. Petitioner underwent a short course of physical therapy and was released to full duty on 7/23/09. Px4:228. He testified that when he had the first accident in 2009 he had pain in the leg and hamstring but that it went away. On cross, Petitioner testified that he did not have low back injuries prior to July 2009. He also stated that he did not see any other doctors other than Concentra for the July 2009 injury.

The Petitioner suffered an undisputed work accident to his low back on 2/22/10. Ax1. The Petitioner was opening a trailer door that got stuck. The petitioner felt a sharp pain in his right low back as he tried to move the door. He said his pain was similar to his prior low back pain but worse. The Petitioner testified his pain on 2/22/10 was different from July, 2009. He testified that it was a very strong pain in his right side. He had never felt that level of pain before he opened the door that day.

The Petitioner reported his injury to Concentra, the company clinic. Px4. Concentra referred Petitioner to physical therapy and put him on light duty. *Id. at 234.* During his continued time with Concentra, radiation of pain to the right buttock, right lateral knee, right thigh, paresthesias, limited range of motion was noted. *Id.* at 234. In addition, it was noted that Petitioner had on/off pain between his prior low back injury and the 2/22/10 injury but that the recent injury "exacerbated symptoms significantly." *Id.* at 236. See also, Rx3.

During this time, on 3/2/10, Petitioner then went to see Dr. Michael Haak, an orthopedic surgeon at Northwestern. Px7:6. Petitioner related his recent work injury and his prior episode of low back pain, which had resolved. *Id.* at 6, 9. Exam showed tenderness to the low back primarily on the right side with reproduction of symptoms and a sciatic distribution of pain down the lateral mid calf. The doctor diagnosed lumbago, lumbar degenerative disc disease, lumbar radiculopathy and sciatica. X-rays showed mild degenerative changes at L4-5 and L5-S1. The doctor noted that based on Petitioner's then current condition, it appeared he had "sciatica with back and leg pain after his on the job injury." He recommended an MRI and that Petitioner be removed from work.

Dr. Haak read the 3/4/10 MRI as showing degenerative changes at L4-5 and L5-S1 with degenerative disc herniation and nerve root compression at both levels. Px7:18. The doctor noted that "based on his current condition," he felt that Petitioner "is symptomatic because of his on the job injury with a strain and likely disc herniation with nerve root compression and radiculopathy." *Id.*, Px6:9-10. Petitioner began a course of outpatient physical therapy with Northwestern Medical. Px7:21-84.

On 4/27/10, Petitioner returned to Dr. Haak noting no real improvement in physical therapy. Px7:84. Exam showed positive straight leg raise on the right. The doctor opined that based on Petitioner's current condition Petitioner was symptomatic because of disc herniations causing underlying nerve irritation. Petitioner was referred for lumbar epidural injections. Petitioner remained off of work. Physical therapy continued thru the end of May. *Id.* at 90-129. On 5/4/10, Petitioner underwent joint injection on the right at L4-L5 and L5-S1 with Dr. Rittenberg of RIC. Px3:205-206. Petitioner testified that the injection did not help. Petitioner had repeat injections with Dr. Rittenberg on 5/4/10.

On 6/1/10, Petitioner followed up with Dr. Haak who noted temporary relief following lumbar injections and continued pain down the right leg, occasionally down the left leg or hip. Noting extensive conservative care, including removal from work, medicine, therapy and injections, all without improvement, Dr. Haak recommended a right-sided minimally invasive L4-5, L5-S1 partial discectomy. Px7:131. On 6/30/10, Dr. Haak performed and Petitioner underwent a right L4-5 and L5-S1 hemilaminectomy and discectomy with L5 nerve root exploration and right L5-S1 minimally invasive discectomy with S1 nerve root exploration. Px1:34-36.

The Petitioner underwent physical therapy following surgery. The Petitioner testified the pain in his back and leg did not fully go away after surgery. Px7. On 8/10/10, Petitioner followed up with Dr. Haak who noted improvement but continued to prescribe additional therapy. Px7:146. On 10/5/10, Petitioner again followed up with Dr. Haak who again referred Petitioner for additional therapy due to back and leg pain. Exam showed positive straight leg raise on the right with reproduction of symptoms. *Id.* at 207. On 11/16/10, Petitioner followed up with Dr. Haak. Petitioner continued to complain of bilateral low back pain radiating primarily down the right leg into the lateral aspect of the right calf. Exam was unchanged from prior exam. Due to increasing symptoms with regard to the right leg, the doctor ordered a Gadolinium enhanced MRI of the lumbar spine to rule out recurrent disc herniation. Medications, off work status and therapies were continued. *Id.* at 265-266. Physical therapy continued with Northwestern Medical through the mid November 2010. Px7:261.

On 11/30/10, Petitioner followed up after his MRI. The doctor ruled out recurrent disc herniation. *Id.* at 272. On 12/28/10, Dr. Haak noted that Petitioner continued to complain of low back pain and right leg pain. It was noted that injections were somewhat helpful and that therapy had not yet been approved. Based on Petitioner's condition, the doctor felt that Petitioner was still symptomatic as a result of his on the job injury, exacerbating his underlying degenerative disc disease and lumbar herniated nucleus pulpous but that is was unclear whether

the on the job injury caused the lumbar disc herniation. Petitioner was given additional medications, referred to RIC for injections and remained off of work. *Id.* at 280.

On 12/17/10, Petitioner underwent a transforaminal lumbar epidural steroid injection on the right at L4-5 and L5-S1 with Dr. Casey of RIC. Px3:191. On 12/27/10, Petitioner was evaluated by Dr. Kornblatt at the request of Respondent. Rx2. The doctor noted Petitioner's medical history relevant to his work injury. He noted that his current complaints after surgery consisted of central and right low back pain at times radiating into the right thigh, leg, foot with paresthesias in the right leg and foot. Petitioner reported 90% low back pain and 10% leg symptoms. Dr. Kornblatt opined that Petitioner injured his back at work on 2/22/10 resulting in mechanical low back pain, referred right leg pain secondary to work related lumbosacral strain. He went on to state that the work related incident did not cause, aggravate or accelerated Petitioner's pre-existing 3-level lumbar degenerative disc disease and did not cause a clinical herniated disk with radiculopathy. The doctor attributed Petitioner's condition to his surgery and noted Petitioner was still in need of additional care due to his deconditioned state and in need of work restrictions. On 2/23/11, Dr. Wehner administered an SI joint injection. Rx3:15. At his evidence deposition, Dr. Haak disagreed with Dr. Kornblatt. Dr. Haak said the Petitioner had sciatica relating from compression of the nerve root at S1 and that his surgery was caused by his work injury exacerbating underlying degenerative changes and also causing disc herniation. Px6:19-21, 53-57.

On 3/2/11, Petitioner was re-evaluated by Dr. Haak. Px7:287. The doctor noted 4 out of 10 pain, residual right sided low back pain and right hamstring pain. Petitioner had not been able to do physical therapy due to lack of approval. Dr. Haak reviewed Dr. Kornblatt's evaluation report and noted that the doctor concluded that Petitioner's residual symptoms were from his surgery and not from the work accident. Dr. Haak noted that "it didn't make a lot of sense since the patient had surgery because of the injury." Dr. Kornblatt recommended work conditioning to address Petitioner's deconditioned state, to which Dr. Haak felt that Petitioner was deconditioned because of lack of insurance approval for work conditioning. Although Dr. Haak believed Petitioner had improved since surgery, he ordered additional medicine, physical therapy and continued to take Petitioner off of work. The doctor did note that Petitioner's recent MRI did show some "slightly increased right sided prominence at the L4-5 disc level," and that if he continued to have radicular complaints that he may need a revision surgery at the affected level. *Id.* at 288.

On 3/9/11, Dr. Wehner released Petitioner from care following the SI joint injection, noting significant improvement. Rx4:13. On 3/31/11, Dr. Haak noted that although Petitioner was stable but not changed due to lack of additional therapy. Px2:112. Petitioner remained off of work and additional therapy was ordered. The doctor suggested work conditioning followed by possible vocational re-education of work conditioning was not successful. *Id.* On 4/27/11, a functional capacity evaluation (FCE) with Accelerated Rehab showed Petitioner could safely perform work at that medium category of work. Px5:281-287.

On 4/6/11, Dr. Wehner reevaluated Petitioner and agreed that additional work conditioning would be appropriate. Rx3:14. On 4/28/11, Petitioner followed up with Dr. Haak,

whose recommendations and opinions remained largely unchanged from the prior visit. Px2:118. On 5/5/11, Petitioner began work conditioning as previously recommended by Dr. Haak at Accelerated Rehab. Px5. On 5/26/11, Dr. Haak reevaluated Petitioner and noted that Petitioner found work conditioning to be helpful. Px2:125.

On 6/23/11, Petitioner returned to Dr. Haak and reported 0 out of 10 pain following work conditioning and that he had lost 19 pounds since beginning work conditioning. Px2:130-131. Exam showed negative straight leg raise. Petitioner's work conditioning with Accelerated Rehab ended on 8/25/11. Px5. On 6/24/11, Dr. Wehner released Petitioner from care. Rx16. She recommended he finish work conditioning.

On 9/7/11, Petitioner followed up with Dr. Haak, who reviewed Petitioner's recent functional capacity evaluation (FCE), which recommended work at the medium to heavy category of work, which matched his pre-injury job. Thus, Dr. Haak released Petitioner to work full duty. Follow up was ordered. Px2:155, Px5:274-280.

On 10/4/11, Petitioner followed up with Dr. Haak, who recorded zero pain and discontinued use of Lyrica. Additional follow up was ordered. Px2:164. On 11/1/11, petitioner returned to Dr. Haak who released Petitioner from care following a normal exam and negative straight leg raise exam.

Petitioner testified that upon his return to work, he worked full duty, by himself and performing the same job duties as before his accident. Since returning, he said he has not complained to anyone at work of any low back pain and that he has not had any other back injuries. He testified he tries to keep fit and does exercises for his low back and that those exercises help. He also keeps fit by playing racquetball. He testified and admitted he recently won a racquetball trophy and identified himself in photo contained inside of Respondent's company newsletter. Rx2. He testified that there are some things that are not true in the paragraphs. For instance, he does not play against professionals but rather it's a local league. He testified he began playing in December 2011 and plays each Sunday for 1 hour. He testified he has never injured his back playing racquetball and that he does not hit it hard. Petitioner has not returned to Dr. Haak since his full duty release for either treatment, follow up or medications. Currently, Petitioner takes over the counter ibuprofen as needed.

CONCLUSIONS OF LAW

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

Having reviewed all evidence submitted at trial and having carefully considered the testimony of the Petitioner, the Arbitrator concludes that the Petitioner's current condition of ill-being is related to the injury of February 22, 2010. In so concluding, the Arbitrator relies on the credible testimony of the Petitioner, his corroborating and timely medical treatment records and adopts and relies on the medical opinions of Dr. Haak.

Petitioner credibly testified as to his prior work accident pre-dating the undisputed 2/22/10 accident as well as to his minimal course of conservative treatment and to his low back pain. Petitioner credibly explained that the 2/22/10 work accident resulted in increased low back pain very different than the low back pain he recalled in his prior work accident. to this end, Petitioner's medical records from both Concentra and Dr. Haak corroborate those statements. In addition, the Arbitrator notes that Petitioner was treatment free from July 2009 until his 2/22/10 work accident. To the extent Petitioner had a prior work accident resulting in pre-existing low back disability or condition, the Arbitrator finds this previous work injury or condition insignificant.

Following his 2/22/10 work accident, medical records from Dr. Haak and Concentra reported radicular pain for the Petitioner. Comparing this to Petitioner's earlier low back injury and treatment, there is no report of radiculopathy associated with the 2009 event. Likewise, there was lost time, extensive physical therapy, injections or surgery following the 2009 event. Px6:24. The MRI following the 2/22/10 event confirmed protrusions traversing the nerve roots at L4-5 and L5-S1. There was no evidence at trial that this pathology occurred as a result of the 2009 injury or that it occurred at some point prior to the 2/22/10 accident in question. Thus, the Arbitrator is persuaded that Petitioner's current condition is the result of his 2/22/10 accident and that that accident was a causative factor in his condition, surgery and current state.

In addressing Dr. Kornblatt's medical opinions on causation, the doctor ultimately concludes that Petitioner injured his back at work on 2/22/10 resulting in mechanical low back pain, referred right leg pain secondary to a work related lumbosacral strain. He went on to state that the incident did not cause, aggravate or accelerated Petitioner's pre-existing 3-level lumbar degenerative disc disease and did not cause a clinical herniated disk with radiculopathy. The Arbitrator is not persuaded that Petitioner's undisputed work accident leading to mechanical low back pain and referred right leg pain resulted in nothing more than a lumbar strain. On the contrary, a preponderance of the medical evidence following the accident shows that Petitioner's subjective complaints and clinical presentation more resembled disc degeneration and pathology (herniation) at L4-5 and L5-S1 as noted on exam and MRI. Dr. Kornblatt's opinion that the work accident did cause mechanical low back pain and radiculopathy but did not cause degeneration or herniated disc suggests to the Arbitrator that, at the very least, the doctor in fact acknowledged the existence of the presence of all aforementioned pathology and conditions. This evidence more points to Petitioner's 2/22/10 work accident either causing or aggravating the mentioned conditions in Dr. Kornblatt's medical evaluation. In short, the Arbitrator is unable to conclude Petitioner's condition is that of lumbar strain. This conclusion is supported by Dr. Haak's opinion, which the Arbitrator adopts, stating that "based on his current condition," he felt that Petitioner "is symptomatic because of his on the job injury with a strain and likely disc herniation with nerve root compression and radiculopathy."

Further, to the extent Petitioner's then current condition of residual low back and leg pain at the time of Dr. Kornblatt's evaluation persisted, it would not be the result of the surgery itself but rather a sequela or consequence of the initial underlying work injury. This conclusion is also supported by Dr. Haak's review of Dr. Kornblatt's opinion, wherein Dr. Haak correctly pointed out that to the extent Petitioner had residual symptoms after surgery, the surgery itself was the

result of the injury. Stated otherwise, but for Petitioner's work accident, Petitioner's surgery and subsequent state of ill-being would not have occurred. In adopting o and relying on the medical opinions of Dr. Haak over those of Dr. Kornblatt, the Arbitrator concludes that a preponderance of the evidence shows Petitioner's current condition is causally related to the original work accident.

ISSUE (L) What is the Nature and Extent of the injury?

Having found in favor of Petitioner on the issue of causal connection, the Arbitrator notes that the nature and extent of Petitioner's low back injury is ripe for consideration as he has been released to work full duty and has been so working per both the medical record and Petitioner's testimony.

The Petitioner is a 47-year-old man in a labor intensive job who suffered a work-related injury to his low back ultimately resulting in and necessitating a L4-5 and L5-S1 hemilaminectomy and discectomy with L5 nerve root exploration and right L5-S1 minimally invasive discectomy with S1 nerve root exploration. Post operatively, he required extended physical therapy and an additional epidural steroid injection. Petitioner also required work conditioning, which eventually rehabilitated him back to work full time within the restrictions given to him following an FCE. Petitioner's recovery was successful and apparent as evidenced in his ability to participate in racquetball. Based on the findings of fact and conclusions herein, Petitioner has sustained permanent partial disability to his low back as a result of the injury. Respondent shall pay Petitioner permanent partial disability benefits of **$638.47/week** for **125** weeks, because the injuries sustained caused the **25%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

ARBITRATOR SIGNATURE

9.25.15
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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeffery Thompson,
Petitioner,

vs. NO: 15WC 12126

Tri-Star Cabinetry & Top Company,
Respondent,

18IWCC0187

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issue of 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 September 21, 2017 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 6 2018

Charles J DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

d032118
CJD/rlc
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THOMPSON, JEFFERY
Employee/Petitioner

Case# **15WC012126**

TRI-STAR CABINETRY & TOP COMPANY
Employer/Respondent

18IWCC0187

On 9/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

2837 LAW OFFICES JOSEPH MARCINIAK
MICHELLE R POWELL
TWO N LASALLE ST SUITE 2510
CHICAGO, IL 60602

18IWCC0187

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
NATURE AND EXTENT ONLY

Jeffrey Thompson
Employee/Petitioner

v.

Tri-Star Cabinetry & Top Company
Employer/Respondent

Case # **15** WC **12126**

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 **Christine Ory**, Arbitrator of the Commission, in the city of **New Lenox**, on **February 14, 2017**. By stipulation, the parties agree:

On the date of accident, **October 7, 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 **$39,250.64**, and the average weekly wage was **$754.82**.

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

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

Respondent shall be given a credit of **$5,673.03** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$5,673.03**.

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 **$452.89**/week for a further period of **55.66** weeks, as provided in Section **8 (e) 10** of the Act, because the injuries sustained caused **22% loss of use of the left arm**.

Respondent shall pay Petitioner compensation that has accrued from **August 24, 2015** through **September 20, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall also pay the outstanding balance of $4,744.49, if not already paid, pursuant to the fee schedule and pursuant to §8 and §8.2 of the Act.

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

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

Christine MOny
Signature of Arbitrator

September 20, 2017
Date

SEP 21 2017

 18IWCC0187

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeffrey Thompson	)	
Petitioner,	)	
vs.	)	**No. 15 WC 12126**
Tri-Star Cabinetry & Top Company	)	
Respondent.	)	

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in New Lenox on February 14, 2017 The parties agree that on October 7, 2013, petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act; that their relationship was one of employee and employer, that petitioner suffered accidental injuries that arose out of and in the course of his employment with respondent and that petitioner's left arm injury was caused by the work accident. They further agree that in the year preceding the injuries, the petitioner earned $39,250.64, and that her average weekly wage was $754.82.

The only matter at issue is the nature and extent of petitioner's left arm injury.

FINDING OF FACTS

Petitioner testified he had been employed by respondent since June, 1999 as a cabinet builder; mass producing lower end cabinets. As such, this job required intensive use of arm and hands as he was required to lift cabinets, use nail and glue guns. Although right handed, he was required to use both arms and hands equally in his job.

On October 7, 2013, petitioner injured his left elbow when picking up a 42-inch by 60-inch cabinet and placing it on top of the base. He reported the injury immediately to his supervisor.

He went to Occupational Medicine Clinic two days later. An MRI was done on October 17, 2013. He was then referred to Dr. Hurbanek at Hinsdale Orthopaedics. He was given a brace and released to return to light duty work. On November 11, 2013 he was released to return to full duty work.

On November 24, 2014, he returned to Dr. Hurbanek; the pain was worse in his elbow. He was given a shot and prescribed surgery. He was referred to Dr. Steven Chudik for second opinion. On January 6, 2015, Dr. Chudik performed surgery to petitioner's left elbow which included insertion of anchors; the anchors remain in petitioner's arm.

He obtained physical therapy at Good Samaritan Hospital. He remained completely off work until March 23, 2015, when, at his request, he was released to return to light duty work. On April 29, 2015, a post-surgical MRI was done. On May 4, 2015, additional physical therapy was ordered. On June 15, 2015, additional X-rays were done. Petitioner was released to full duty work and home exercises on August 25, 2015.

Petitioner obtained his own lighter duty by changing position to building "special" cabinets. This reduced the number of cabinets he built from twelve to one or two a day.

Petitioner continues to have soreness in his arm. He doesn't do the family activities he once did. He cannot golf; he has problems fishing; he can't pick up his daughter; he can't carry his bike up and down stairs.

He no longer volunteers for overtime as he can't work more than eight hours; however, he does work Saturdays. He puts heat on the arm in the morning and ices it at night. He does stretching exercises.

Dr. Jeffrey Coe performed an examination of petitioner, and provided an AMA rating on October 11, 2016, at respondent's request.

On cross-examination petitioner greed he advised Dr. Chudik at his last visit in August, 2015 that he was working without pain and was not taking any prescribed pain medication; only Ibuprofen.

Since returning to work, has been paid his pre-injury wages. He used to use a nail gun, sanders and saws, but now does more intricate work, using only some of these tools he previously used. The intricate work is not as repetitive. He agreed he had not always work overtime before the accident.

Medworks Records (PX.1)

Petitioner was seen on October 8, 2013 for the left elbow injury. Diagnosis was left elbow biceps strain. An arm sleeve, Ibuprofen and restricted work was prescribed. X-rays were negative for fracture or dislocation.

Petitioner returned on October 7, 2013. Diagnosis was left biceps tendon sprain and left triceps strain. An MRI was ordered and kept on restricted work.

Petitioner was seen again on October 21, 2013 after obtaining an MRI on October 17, 2013. The MRI was reported as showing an intermediate grade partial tear of the common extensor originating off the lateral epicondyle. He was referred for physical therapy and to an orthopedic surgeon for follow up. He remained on restricted work.

Petitioner did not return to the clinic until November 11, 2014; he returned due to an acute exacerbation of elbow pain that had been worsening over the last several months. Petitioner reported weakness in the arm as well as pain in the left elbow. Weakness was report as 3/5 on the left as compared with 5/5 on the right. Diagnosis was partial tear common extensor tendon of the lateral epicondyles of the left elbow and lateral epicondylitis of the left elbow. Surgery was recommended.

Future Diagnostics Group October 17, 2013 Left elbow MRI report (PX.2)

The MRI showed a normal appearance of the biceps tendon and intermediate grade partial tear of the common extensor tendon originating at the lateral epicondyle.

ATI Physical Therapy Records (PX.3)

Petitioner received physical therapy for a neck injury he suffered in a motor vehicle accident in January, 2014 (P.8-66).

Petitioner received physical therapy for his left arm injury in October through December, 2013 (P.67-95).

Hinsdale Orthopaedics Associates Records (PX.4; 4a; 4b)

Petitioner was seen by Dr. Hurbanek on October 24, 2013. Dr. Hurbanek reviewed the October 17, 2013 MRI study and agreed with the finding of the radiologist. Dr. Hurbanek performed a cortisone injection. A counterforce strap and work restrictions were provided.

On November 11, 2013, petitioner was released to return to work full duty and from doctors' care; to return as needed.

Petitioner did not return until November 24, 2014, at which time he wished to proceed with surgery. He was seen by Dr. Chudik as a referral from Dr. Hurbanek on December 1, 2014. Dr. Chudik recommended left elbow open lateral extensor debridement. Petitioner had a pre-surgery visit on January 5, 2017.

On January 6, 2015, Dr. Chudik performed an open left extensor tendon debridement and repair with insertion of anchors.

At the post-op visit on January 19, 2015, petitioner underwent an X-ray due because of some ongoing concerns. The X-rays showed the hardware was intact and aligned well. Petitioner was placed in a cock-up splint and physical therapy was ordered. Petitioner was to remain off work completely. He followed up with Dr. Chudik on February 11, 2015.

On March 23, 2015, petitioner reported he was 95% better with physical therapy and asked to return to work. He was released to return to work with restrictions. On April 22, 2015, petitioner reported he had developed a sharp pain in his elbow within a month after returning to work. He was released to return to work with restrictions.

A repeat MRI was done on April 30, 2015 showed surgical changes as well as possible scarring and/or tendinosis.

On May 4, 2015, additional physical therapy and work restrictions were ordered. On June 15, 2015, petitioner was making improvements in physical therapy, but the pain remained. A repeat X-ray was done on June 15, 2015, that showed proper alignment.

On August 24, 2015, petitioner was released from doctors' care having reached maximum medical improvement. Petitioner reported the sharp shooting pain had subsided but he had slight pain consistently.

Hinsdale Hospital Records (PX.5; 5a)

Petitioner was hospitalized for the January 6, 2015 surgery as described in PX.4.

Good Samaritan Hospital Records (PX.6)

Records of physical therapy from January, 2015 to June, 2015.

Dr. Jeffrey Coe's October 11, 2016 Report & January 20, 2017 Deposition (PX.7 & PX.8)

[Although these two exhibits were withdrawn as both Dr. Coe's deposition and report were introduced as Joint Exhibit 1, nonetheless were included with the other exhibits introduced.]

Suburban Radiologist Bill (PX.9)

The claimed amount of the bill is $412.00 that was fully paid by respondent.

Hinsdale Orthopaedics Bill (PX.10)

The claimed amount of the bill is $13,536.00; with a claimed balance due of $4,699.00 for services rendered Michelle Peiss PAC for assistance in the surgery of January 6, 2015.

DuPage Pathology Associates Bill (PX.11)

The entire bill claimed of $290.00 was fully paid.

Good Samaritan Hospital Bill (PX.12)

The total bill for physical therapy from January 22, 2015 through January 29, 2015 of $2,569.00 was fully paid.

Good Samaritan Hospital Bill (PX.13)

The bill for physical therapy for services rendered from February 3, 2015 through February 26, 2015 totaling $1,219.00 was fully paid.

Good Samaritan Hospital Bill (PX.14)

The bill for physical therapy from March 3, 2015 through March 19, 2015 totaling $2,466.00 was fully paid.

Good Samaritan Hospital Bill (PX.15)

The bill for physical therapy from April 6, 2015 through April 16, 2015 totaling $1,537.00 shows a remaining balance of $45.49.

Dr. Jeffrey Coe January 20, 2017 Deposition and October 11, 2016 Report (Joint Ex.1)

Dr. Jeffrey Coe is a board certified specialist in Occupational Medicine and certified by the American College of Disability Medicine and University of Illinois Medical Center to perform AMA impairment ratings (5-7). He examined petitioner on October 11, 2016 at respondent's request (9). Dr. Coe prepared a report of his examination of petitioner and review of the medical records (11; Ex.2).

Dr. Coe provided his analysis, utilizing the AMA Guides to the Evaluation of Permanent Impairment; Sixth Edition, to arrive at an impairment rating of 6% of the left upper extremity based upon his examination of the petitioner and review of the treating medical records (17-22).

Dr. Jeffrey Coe Impairment Rating Report (RX.1)

Dr. Coe provided an impairment rating of 6% of the left upper extremity based upon a default rating of 5% for status post lateral epicondylar release surgery with residual symptoms, with a total grade modification of +2.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

In support of the Arbitrator's decision with regard to the nature and extent of injury, the Arbitrator makes the following conclusions of law:

As a result of the October 7, 2013, petitioner sustained a partial tear of the common extensor tendon of the lateral epicondyles of the left elbow and lateral epicondylitis of the left elbow which required an open repair with insertion of anchors; the anchors remain.

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:

With regard to subsection (i) of §8.1b (b) the Arbitrator notes on October 11, 2013, Dr. Coe provided a permanent partial disability impairment rating of 6% of the left upper extremity. The Arbitrator gives some weight to this factor.

With regard to (ii) of §8.1b (b) the occupation of the injured employee, the Arbitrator notes petitioner was employed as a cabinet maker. As such, petitioner would be required to use both hands and arms extensively. Therefore, the Arbitrator gives more weight to this factor.

With regard to (iii) of §8.1b (b) the age of the employee at the time of the injury was 46 years of age, and was 49 at the time he testified. Therefore, the Arbitrator gives some weight to this factor.

With regard to (iv) of §8.1b (b) the employee's future earning capacity, the Arbitrator notes petitioner made his own accommodations by changing the work he performs for respondent to avoid repetitive and not taking overtime work. However, there is no indication his pay has been reduced. The Arbitrator, therefore, gives little weight to this factor.

With regard to (v) of §8.1b (b) evidence of disability corroborated by the treating medical records, the Arbitrator notes the medical records substantiate petitioner underwent open surgical repair of the partial tear of the common extensor tendon of the lateral epicondyles of the left elbow and lateral epicondylitis of the left elbow with insertion of anchors that remain. Petitioner also underwent extensive physical therapy after the surgery.

At his last visit with Dr. Chudik on August 24, 2015, petitioner reported he continued to work without much pain; does ice the elbow after working and does stretching exercises. Dr. Chudik noted point tenderness at the lateral elbow. Dr. Coe confirmed this same finding at the time of his examination of the petitioner on October 11, 2016. Petitioner does not take any prescribed pain medication. The Arbitrator therefore gives some 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 22% loss of use of the left arm § 8 (e) 10 of the Act.

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

Margaret Barnes,

Petitioner,

vs. NO: 12WC 38353

The Gap, Inc.,

Respondent,

18IWCC0188

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 26, 2016 is hereby affirmed and adopted.

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

18IWCC0188

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 6 2018

o032118
CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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

BARNES, MARGARET
Employee/Petitioner

Case# **12WC038353**

THE GAP INC
Employer/Respondent

18IWCC0188

On 7/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0878 COLLISON & O'CONNOR LTD
E K COLLISON III
19 S LASALLE ST SUITE 1400
CHICAGO, IL 60603

2542 BRYCE DOWNEY & LENKOV LLC
MICHAEL C MILSTEIN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

18IWCC0188

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

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

Margaret Barnes
Employee/Petitioner

v.

The Gap, Inc.
Employer/Respondent

Case # **12** WC **38353**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva** on **June 15, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [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?
[x] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On the date of accident, September 30, 2012, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $20,219.16; the average weekly wage was $388.83.

On the date of accident, Petitioner was 54 years of age, *married* with no dependent children.

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

Respondent shall be given a credit of $0 for TTD, $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

As explained in the Arbitration Decision Addendum, Petitioner has established a causal connection between her current condition of ill-being and her accident at work. However, Petitioner has failed to establish her entitlement to temporary partial disability benefits commencing October 9, 2012 through January 1, 2013 and April 25, 2013 through May 16, 2013 as claimed.

Medical Benefits

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibits that remain unpaid as well as Petitioner's out-of-pocket costs for such services pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator awards the prospective medical care in the form of pain management including a nerve root blockade as prescribed by Dr. Sokolowski pursuant to Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

July 26, 2016
Date

JUL 26 2016

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

Margaret Barnes
Employee/Petitioner

v.

The Gap, Inc.
Employer/Respondent

Case # **12** WC **38353**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute include causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to temporary partial disability benefits from October 9, 2012 through January 1, 2013 and April 25, 2013 through May 16, 2013, and whether Petitioner is entitled to prospective medical care in the form of pain management including a nerve root blockade as ordered by Dr. Sokolowski. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Employment & Background

Margaret Barnes (Petitioner) testified that she was employed by the Gap, Inc. (Respondent) in 2011 and through the date of accident as a Customer Service Representative. In her position, Petitioner ensured that merchandise was set up for display and she worked with customers. The physical requirements of the position included twisting, turning, getting stock out of the back and carrying it to the front of the store, and bending.

On September 30, 2012, Petitioner was at work when a customer asked her for a certain item that was not on the floor. After inquiring of a manager as to the location of the item, Petitioner went to the back of the store and got a ladder to retrieve the item off of a shelf located above a refrigerator. Petitioner climbed the ladder and leaned over the top of the refrigerator to reach the item. As she was reaching for the item, Petitioner testified that she fell and landed on her back on the floor. She explained that she was in a lot of pain after she fell, so much so that she could not breathe. Petitioner explained that she sat there for a while and was attended by her managers and co-workers. Soon thereafter, a supervisor took Petitioner to the hospital.

Medical Treatment

The medical records reflect that Petitioner presented at the emergency room at Provena Mercy Medical Center on September 30, 2012. PX1. She underwent x-rays of the back and pelvis. *Id.* Petitioner's thoracic x-ray revealed mild anterior compression of T12, age uncertain. *Id.* The interpreting radiologist recommended an MRI to assess acuteness. *Id.* David Sanchez, M.D. (Dr. Sanchez) diagnosed Petitioner with a back contusion and possible T12 compression fracture status post fall. *Id.*

On October 1, 2012, Petitioner returned to Provena Mercy Medical Center and saw Charles Woodward, M.D. (Dr. Woodward). PX1. He noted a history from Petitioner in which she reported that she was on a ladder

[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. Exhibits attached to depositions will be further denominated with "(Dep. Ex. _)."

approximately five feet in the air when the ladder became unstable and she fell backward landing onto the concrete floor. *Id.* Subsequently, Petitioner reported pain with attempting to move from a lying or seated position and with taking a deep breath. *Id.* Dr. Woodward noted that Petitioner's x-rays were negative for fracture and performed a physical examination. *Id.* He diagnosed multiple contusions secondary to her fall and noted that there was a question about the age of Petitioner's T12 fracture, which he suspected was a new event. *Id.* Petitioner returned to Dr. Woodward on October 3, 2012 reporting some pain radiating up and down her spine and he noted that she pointed "right to T12 for her pain." *Id.* Dr. Woodward referred Petitioner for an orthopedic evaluation and treatment. *Id.*

On October 9, 2012, Petitioner saw Craig Popp, M.D. (Dr. Popp) at Fox Valley Orthopaedic Institute for the first time as referred by Dr. Woodward. PX2. She reported an injury at work when she fell flat on her back on a concrete floor from a height of 5-6 feet. *Id.* After an examination and reviewing her x-rays, Dr. Popp ordered a back brace and MRIs. *Id.* He noted that Petitioner's fracture at T12 was most likely acute, but he was concerned about her low back pain and its source. *Id.* He placed Petitioner on sedentary work restrictions with no repetitive bending or twisting. *Id.*

Petitioner underwent the recommended MRIs on October 16, 2012. PX2. The interpreting radiologist compared Petitioner's MRIs with the plain radiographs taken on October 9, 2012. *Id.* He found an acute compression fracture of T12 and that the signal changes in the anteroinferior portion of T11 was secondary to chronic degenerative disc disease. *Id.* Petitioner then saw Dr. Popp on October 18, 2012. *Id.* He noted that the lumbar and thoracic MRIs showed a compression deformity involving T12 and a fracture line as well as minimal retropulsion in that area. *Id.* Dr. Popp also noted some degeneration involving the lumbar spine that may have been acutely exacerbated. *Id.* He diagnosed Petitioner with a closed fracture of the thoracic vertebral body and kept her on light duty work restrictions. *Id.*

On December 26, 2012, Petitioner saw Dr. Popp's physician's assistant, Adam Weaver, PA-C, who maintained Petitioner's diagnosis of a compression deformity involving T12, but released her to full duty work effective January 1, 2013. PX2. However, Petitioner was also prescribed physical therapy twice per week the following day on December 27, 2012 for the thoracic fracture. *Id.*

On December 31, 2012, Dr. Popp noted that Petitioner had some de-conditioning following her initial injury and he recommended six weeks of physical therapy with a subsequent follow up visit. *Id.* On January 4, 2013, Petitioner was placed on work restrictions with no lifting over 10 pounds and no repetitive bending. *Id.* Petitioner testified that she underwent physical therapy, but explained that it caused more pain.

Utilization Review – TENS Unit

Respondent requested a utilization review related to Dr. Popp's order for a TENS unit. PX2; RX2. The request was non-certified by Dr. Martin Plotkin (Dr. Plotkin). *Id.* He noted that "[i]n this case, although the claimant reports prior positive response; specific objective and functional gains related to TENS unit use in the clinical setting are not outlined. The claimant has received recent physical therapy which should have included instruction in a home program to include at home modality use to manage symptoms. Given such, medical necessity is not supported by clinical documentation or evidence-based medicine guidelines. Recommend non-certification." *Id.*

Continued Medical Treatment

On February 19, 2013, Petitioner returned to Dr. Popp. PX2. She reported that she did not receive the TENS unit, but she did go through physical therapy, which improved her core strength. *Id.* However, Petitioner also reported continued pain over the left side of the back and some over on the right side as well as tingling down the back on the left side near the ribs. *Id.* Petitioner reported that the back pain was not significantly improved. *Id.* Dr. Popp ordered a thoraco-lumbar MRI to assess whether Petitioner's fracture had healed or if there was avascular necrosis there. *Id.* He also ordered a chest CT scan to determine the source of Petitioner's rib pain and whether there was subluxation of the rib off the costvertebral junction or whether there was some other abnormality. *Id.* He also reiterated that Petitioner would benefit from a TENS until and maintained her work restrictions. *Id.*

On February 22, 2013, Petitioner underwent an initial physical therapy evaluation at Physiotherapy Associates. PX3. She then underwent the recommended chest CT scan on March 7, 2013. PX2; PX3. The interpreting radiologist noted a compression deformity of the T12 vertebral body with some buckling of the posterior cortex, some degenerative irregularity at T11-T12 and loss of vertebral height at approximately 40%. *Id.* Petitioner also underwent the recommended MRI on March 9, 2013. *Id.* The interpreting radiologist noted a subtle posterior disc bulge with no central canal narrowing or significant neural foraminal stenosis at T11-T12 and mild posterior retropulsion involving the superior posterior corner of the T12 vertebral body that was stable causing only slight thinning of the ventral CSF space. *Id.*

Two days later, on March 11, 2013, Petitioner saw Dr. Popp who reviewed her recent CT scan and MRI. PX2. Petitioner reported back pain on the left that she described as feeling like a rib was out of place. *Id.* Dr. Popp noted that Petitioner's MRI showed solid healing, but some accelerated degenerative changes at the level of the fracture and some degenerative changes in the lumbar spine. *Id.* He diagnosed Petitioner with a rib contusion noting that he felt no abnormality of the rib, but there was a question of the chondral cartilage matching up with the rib such that there was mild irritation to that area. *Id.* Dr. Popp recommended an additional six weeks of physical therapy, kept Petitioner on light duty, and noted that, hopefully, she would be at maximum medical improvement in about three months. *Id.*

On April 25, 2013, Petitioner reported continued pain and discomfort in the rib region with worsened pain when she tried to bend forward which was required of her job when folding clothes. *Id.* Dr. Popp noted that Petitioner may have a cartilaginous portion of the tip of the rib that had a tear versus a non-healed rib fracture. *Id.* He noted that it was difficult to tell with the CT scan and appreciating nothing abnormal. *Id.* Dr. Popp recommended a bone scan with SPECT imaging to see if there was increased activity that may explain Petitioner's pain and whether or not a localized injection might be helpful. *Id.* Petitioner was placed off of work. *Id.* She then underwent the recommended bone scan on May 14, 2013, which showed increased radiotracer seen at the T12 level within the vertebral body that was consistent with an acute compression fracture. *Id.* The bone scan also showed increased radiotracer uptake in the left lateral aspect of the T10 vertebra that may be at the left costovertebral junction and from degenerative changes as well as a mild focal fracture at the posterior medial margin of the left 10th rib that could not be excluded. *Id.*

On May 16, 2013, Petitioner returned to Dr. Popp reporting continued back and rib pain since her fall at work. PX2. She also reported left rib pain and that recently, after a long car trip, she felt unable to function for two days due to the amount of pain that she was experiencing. *Id.* Petitioner reported that she felt that the rib was continuously inflamed and irritated despite conservative treatment. *Id.* She also reported that the mid-back pain toward the thoracic region was somewhat improved. *Id.* Dr. Popp reviewed Petitioner's recent diagnostic test

results noting that she had increased activity of the left costovertebral junction, which was due to the injury as well as some irritation to that joint secondary to the fall. *Id.* He diagnosed a T10 rib fracture at the medial aspect near the intercostals region with intercostals joint irritation and he referred Petitioner for a pain management consultation with Dr. Siodlarz for an intercostals injection down to the T10 location to help alleviate some of the rib pain, swelling and irritation. *Id.* Dr. Popp also kept Petitioner restricted to light duty work. *Id.*

Petitioner was discharged from physical therapy at Physiotherapy Associates on May 30, 2013. PX2. She testified that she still had mid-to lower back pain at this time.

First Section 12 Examination – Dr. Lami

On June 18, 2013, Petitioner saw Babak Lami, M.D. ("Dr. Lami") at Respondent's request. RX1 (Dep. Ex. 4). Petitioner testified that Dr. Lami made her bend, but never examined her or palpated her back to locate the bump on her back.

Dr. Lami's report reflects that he took a history from Petitioner, examined her, reviewed various treating medical records, and rendered opinions regarding her physical condition. *Id.* At the time of this evaluation, Petitioner reported falling off of a ladder at work at a height of approximately 5-6 feet with an injury to her lower back. *Id.* She localized the majority of her pain to a point on the left side of the thoracolumbar junction over the ribs with occasional tingling in the right buttock and no symptoms of radiculopathy. *Id.*

Dr. Lami noted no cervical, thoracic or lumbar spine tenderness to palpation. *Id.* He also noted that Petitioner localized her pain to the rib cage, which was non-tender to palpation. *Id.* Dr. Lami diagnosed Petitioner with an acute traumatic T12 compression fracture as a result of her fall at work. *Id.* He noted that he was unsure if the recommended intercostals nerve block would provide Petitioner with relief, but indicated that it was not unreasonable. *Id.* Dr. Lami noted that Petitioner could continue her work as a receptionist. *Id.*

Continued Medical Treatment

Petitioner saw Christopher Siodlarz, D.O. (Dr. Siodlarz) for the first time on June 26, 2013. PX2. She reported a fall on September 30, 2012 with an immediate onset of pain and a compression fracture at T12. *Id.* Dr. Siodlarz noted his review of Dr. Popp's medical records and diagnostic test results. *Id.* On physical examination, Dr. Siodlarz noted slight kyphosis and pain from T9-T11 focused at the left T10 posteromedial margin. *Id.* He also noted some mild spasms at those levels. *Id.* Dr. Siodlarz diagnosed Petitioner with traumatic left T10 intercostal neuralgia, left T10 fracture and a chronic T12 vertebral fracture. *Id.* He ordered a topical analgesic, Voltaren, and recommended an intercostals nerve block at the left T10 level given Petitioner's continued pain at that level and positive bone scan. *Id.* Dr. Siodlarz also noted that Petitioner may need more than one nerve block to get the desired result, or that the injection might not work at all. *Id.*

Petitioner underwent the recommended left T10 intercostal nerve block on July 9, 2013. *Id.* Petitioner testified that she did not notice a lot of change as a result of this injection.

Petitioner testified that she then went to see her primary care physician, Julie Potzik, M.D (Dr. Potzik) who referred her to a specialist. The medical records reflect that on August 13, 2013 Petitioner saw Mark Sokolowski, M.D. (Dr. Sokolowski) as referred by Dr. Potzik. PX5. Petitioner testified that she reported a lot of mid and low back pain with left sided pain at this time.

Dr. Sokolowski's medical records reflect Petitioner's report that she fell at work on September 30, 2012 resulting in a compression fracture at the thoracolumbar junction as well as the onset of left-sided periscapular and rib pain. *Id.* On examination, Dr. Sokolowski noted a palpable prominence at the thoracolumbar junction corresponding to the spinous process of T12 at the area of relative segmental kyphosis. *Id.* Dr. Sokolowski diagnosed Petitioner with a T12 compression fracture, which healed into segmental kyphosis with approximately 40% height loss per imaging reports and persistent left periscapular and rib pain. *Id.* He noted that a trigger point injection did not provide Petitioner with relief, so he recommended a thoracic epidural steroid injection and, alternatively, an intercostal nerve block instead of trigger point injections. *Id.*

Utilization Review – Diagnostic & Therapeutic Thoracic Epidural Steroid Injection

Respondent requested a utilization review related to Dr. Sokolowski's order for a thoracic epidural steroid injection. PX2; RX2. The request was certified by Dr. James Anderson (Dr. Anderson). *Id.* He noted that "[i]n this case, the claimant presents with pathology at T11 and T12 on imaging and complains of pain around the ribs covering the T10-T11 range. The claimant has failed all other conservative treatment and trigger point injections. Given such, the proposed 'caudal thoracic' epidural steroid injection is reasonable for diagnostic and therapeutic purposes. Recommend certification." *Id.*

Continued Medical Treatment

Petitioner returned to Dr. Siodlarz on November 19, 2013. PX2. He agreed with Dr. Sokolowski's recommendation for a trial epidural steroid injection and maintained Petitioner's work restrictions. *Id.* Petitioner underwent the recommended thoracic epidural steroid injection at T12-L1 on December 31, 2013. *Id.* Petitioner testified that her pain subsided somewhat after the injection for several weeks, but she continued to see mid- to lower back pain.

On January 23, 2014, Petitioner returned to Dr. Sokolowski. PX5. She reported that the injection gave her some good relief for a couple of weeks after which her pain returned. *Id.* Dr. Sokolowski maintained his diagnoses and ordered a repeat injection given the good relief noted after the first injection. *Id.* He also noted that Petitioner would likely require ongoing pain management to include up to three epidural steroid injections each year as well as analgesics and topical pain medications. *Id.*

Utilization Review – Thoracic Epidural Steroid Injections up to Three Times per Year

Respondent requested a utilization review related to Dr. Sokolowski's order for thoracic epidural steroid injections up to three times per year. PX5; RX2. The request was non-certified by Dr. James Anderson. *Id.* He noted that "[i]n this case, the claimant had a recent thoracic injection on 12/31/13 with good relief reported; however, there are limited further specific details outlined in the submitted records including the percentage of relief and specific functional benefit. Absent further clear and detailed documentation, the requested intervention is not supported by the evidence-based guidelines or submitted clinical records. Recommend non-certification." *Id.*

Dr. Anderson also noted under "Evidence citations for ESI" that "(4) Diagnostic Phase: At the time of initial use of an ESI (formally referred to as the 'diagnostic phase' as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended is there is inadequate response to the first block (<30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a

question of the pain generator (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections." *Id.*

Second Section 12 Examination – Dr. Lami

On May 1, 2014, Petitioner returned to Dr. Lami at Respondent's request. RX1 (Dep. Ex. 3). Dr. Lami diagnosed Petitioner as status post traumatic T12 compression fracture with musculoskeletal pain involving the lower thoracic area and left side of the lower thoracic rib cage. *Id.* He indicated that Petitioner's work accident resulted in her fracture, which had healed. *Id.* Dr. Lami disagreed with the recommendation for epidural injections, which helped her at most for two weeks and would help her for even less time in the future. *Id.* He also disagreed with any recommendation for a spinal cord stimulator, which was a controversial procedure and mainly for nerve pain such as numbness and extremity pain. *Id.* Dr. Lami placed Petitioner at maximum medical improvement, indicated that no work restrictions were necessary, and opined that her care and treatment to date had been reasonable and necessary. *Id.*

Continued Medical Treatment

Through May 2, 2014, Petitioner also sought treatment for an unrelated left foot condition with Dr. Bartel at Fox Valley Orthopaedic Institute. PX2.

Petitioner also testified that, between her last injection and seeing Dr. Sokolowski, she felt worse pain in the mid- to lower back. On July 3, 2014, Petitioner returned to Dr. Sokolowski. PX5. He noted that Petitioner remained symptomatic and that the recommended repeat epidural steroid injection had not yet been approved. *Id.*

Deposition Testimony – Dr. Sokolowski

On October 9, 2014, Petitioner called Dr. Sokolowski as a witness and he gave testimony at an evidence deposition regarding Petitioner's medical treatment and his opinions. PX9. Dr. Sokolowski is a board-certified orthopedic surgeon specializing in the spine. PX9 at 4-6; PX9 (Dep. Ex. 1).

Dr. Sokolowski testified that Petitioner's acute compression fracture at T12 and bony retropulsion as noted in the October 16, 2012 MRI was causally related to her fall from the ladder at work. PX9 at 11-12. He also testified that Petitioner's pathology at T11 was likely an adjacent fracture caused by her injury at work. *Id.*, at 12-13. Dr. Sokolowski explained that Petitioner's persistent pain and symptoms at the thoracolumbar junction were causally related to her injury at work. *Id.*, at 16-17.

As of January 23, 2014, Dr. Sokolowski explained that he recommended a thoracic epidural steroid injection. PX9 at 17-18. This injection was approved by the insurer and administered to Petitioner. *Id.*, at 18. The injection provided two weeks of relief, which Dr. Sokolowski testified validated his diagnosis and strongly suggested that another epidural injection was reasonable. *Id.*, at 18; see also, *Id.*, at 35-36, 38.

Dr. Sokolowski also explained that Petitioner had a healed compression fracture as well as junctional kyphosis because the compression fracture healed into height loss and persistent left periscapular pain. PX9 at 20-21. He testified that these were related to Petitioner's fall at work and that the kyphosis at the thoracolumbar junction may result in increasing back pain, further compression fractures, nerve root involvement and loss of function.

Id., at 21.

On cross examination, Dr. Sokolowski acknowledged that he had not seen Petitioner since July and that he was not aware whether the last topical analgesic (patch) prescribed to her provided relief. PX9 at 40-42. He indicated that there were other topical analgesics available, which he would be happy to prescribe to Petitioner if the insurer would approve them despite his estimation of the high cost as compared to the recommended injections. *Id.*, at 41-42.

On re-direct examination, Dr. Sokolowski addressed the utilization reviews performed by Dr. Anderson. PX9 at 42-46. He indicated that he was not aware of Dr. Anderson's specialization and only understood from the reports that he was an orthopedic surgeon. *Id.*

Continued Medical Treatment

As of October 16, 2014, Dr. Sokolowski noted that Petitioner remained symptomatic and reiterated his recommendation for a repeat epidural steroid injection. PX5. On December 8, 2014, Petitioner returned to Dr. Siodlarz who reiterated that a thoracic epidural steroid injection was appropriate and he maintained Petitioner's work restrictions. *Id.* Petitioner eventually underwent the recommended repeat thoracic epidural steroid injection at T12-L1 on December 11, 2014. PX2. Petitioner testified that her pain subsided somewhat after this injection.

On December 31, 2014, Petitioner returned to Dr. Siodlarz. PX2. She reported an 80% improvement after her last epidural steroid injection, but also reported that her mother was hospitalized and she had to bend repetitively and stand over the bed to assist her with subsequent low back pain at the L5-S1 level. *Id.* Given Petitioner's significant improvement after the epidural steroid injection, Dr. Siodlarz recommended a third thoracic epidural steroid injection. *Id.* Petitioner underwent the third thoracic epidural steroid injection on January 22, 2015. *Id.* Petitioner testified that after this injection her pain was not as severe, but it returned after a few weeks.

On February 9, 2015, Petitioner reported to Dr. Siodlarz that she had significant improvement in her pain including a reduction in pain from a level of 7-8/10 to 3-4/10 and no pain when taking deep breaths. *Id.* Dr. Siodlarz recommended a home exercise program and released her from his care noting that if she had a recurrence or worsening of symptoms, that she would be a candidate for a subsequent epidural steroid injection. *Id.* Petitioner testified that this was her last visit with Dr. Siodlarz.

On May 22, 2015, Petitioner testified that she told Dr. Sokolowski that she still had constant pain in the mid to lower back, particularly where the break was located. PX5. Dr. Sokolowski's records reflect Petitioner's report of increased symptomatology with a greater prominence over the spinous processes at the thoracolumbar junction. *Id.* Dr. Sokolowski diagnosed Petitioner with a T12 compression fracture, which healed into segmental kyphosis with approximately 40% height loss per imaging reports, increasing symptoms at the thoracolumbar junction and persistent left periscapular and rib pain. *Id.* He indicated that Petitioner had known segmental kyphosis as a consequence of her compression fracture at the thoracolumbar junction and that the kyphosis at that segment resulted in prominence of the spinous processes in "this thin patient [that resulted] in rather severe pain when sitting against any firm surface." *Id.* Dr. Sokolowski indicated that Petitioner was at risk for new compression fractures at adjacent levels due to redistribution of stresses and he ordered new thoracic and lumbar x-rays as well as a lumbar MRI. *Id.*

Petitioner underwent the recommended x-rays on June 22, 2015. PX5. However, the recommended MRI was denied by the workers' compensation insurance carrier. *Id.* Petitioner testified that she paid for these diagnostic tests herself.

Petitioner returned to Dr. Sokolowski on June 29, 2015. PX5. She reported increasingly severe symptoms at the thoracolumbar junction. *Id.* Dr. Sokolowski added a diagnosis of increasing symptoms at the thoracolumbar junction including radiating left T12 intercostal nerve pain and he ordered pain management including a nerve root blockade, which he indicated was directly related to her injury at work. *Id.*

Motor Vehicle Accident

Petitioner testified that she was involved in a motor vehicle accident in July of 2015. She explained that she had neck and some back pain, but this pain was not related to her prior back pain. She also testified that it only lasted a few days and she only went to the emergency room.

The medical records reflect Petitioner presented for emergency room care on July 3, 2015. PX10. The nursing notes reflect a history that "Pt states that she was involved in a car accident on tuesday of this week and has neck pain, lower back pain and pain in both arms with movement. Pt was driving and got rear ended on Kirk and Cherry road. A/Ox3, skin warm and dry, respirations regular and unlabored. Upper body is tense." *Id.* Petitioner was evaluated by a physician who noted that Petitioner's accident did not involve deployment of her vehicle's air bag. *Id.* She also reported chronic mid-low back pain. *Id.* The emergency room physician diagnosed Petitioner with a cervical strain and lumbar strain as a result of the motor vehicle accident. *Id.* She was released to return home. *Id.*

Third Section 12 Examination & AMA Guides Impairment Rating – Dr. Lami

On October 8, 2015, Petitioner returned to Dr. Lami a third and final time at Respondent's request. RX1 (Dep. Ex. 2). Dr. Lami maintained that Petitioner had a healed T12 compression fracture and that her subjective complaints appeared to be related to the injury at work from a "chronological standpoint." *Id.* However, he also indicated that Petitioner's multi-level degenerative disc disease may also be contributing to her condition and it was not related to her injury at work. *Id.*

Dr. Lami disagreed with the recommendation for epidural injections or any nerve ablation procedure, maintained that Petitioner was at maximum medical improvement, and indicated that no work restrictions were necessary. *Id.* He also indicated, contrary to Dr. Sokolowski, that Petitioner was not at risk for a new compression fracture and noted that Petitioner's pain reports at the time of this examination did not follow any particular nerve such that he disagreed with Dr. Sokolowski's recommendation for pain management to address left intercostal nerve pain. *Id.*

Dr. Lami assessed Petitioner's condition pursuant to the AMA Guides and concluded that her one level thoracic compression fracture with 40% compression was 7% of the person as a whole. *Id.*

Continued Medical Treatment

Petitioner then sought chiropractic care as she was not getting other relief. On cross examination, Petitioner testified that she stopped receiving chiropractic care after about 3-4 sessions. Petitioner testified that she sought this chiropractic care as referred by Dr. Sokolowski. See PX11.

Deposition Testimony – Dr. Lami

On March 3, 2016, Respondent called Dr. Lami as a witness and he gave testimony at an evidence deposition regarding Petitioner's medical treatment and the opinions contained in his report. RX1. Dr. Lami is a board-certified orthopedic surgeon who performs spine surgeries. RX1 at 4-9; RX1 (Dep. Ex. 1). He is also certified by the American Board of Independent Medical Examiners for AMA Sixth Edition Impairment Ratings. RX1 at 8.

Dr. Lami testified that as of his 2015 examination, Petitioner's T12 fracture was related to her fall at work. RX1 at 11. He also believed that Petitioner's subjective complaints were causally related to the fall at work from a chronological standpoint. *Id.*, at 11-12. However, Dr. Lami did not believe that Petitioner's multi-level disk degeneration was related to the accident at work. *Id.*, at 12. He placed Petitioner at maximum medical improvement after the one injection he recommended in the May 29, 2013 report and testified that, as of his 2015 examination, Petitioner was working, and could work, full duty. *Id.*, at 12-13.

Dr. Lami also testified that he disagreed with Dr. Sokolowski's treatment recommendation for three epidural injections per year. RX1 at 14-15. He testified that epidural injections were for radicular, sciatic pain and Petitioner had a compression fracture. *Id.* Dr. Lami also cited to the American Academy of Orthopedic Surgeons' website which lists epidural injections as weak for treatment results in compression fracture cases. *Id.*

On cross examination, Dr. Lami acknowledged that Petitioner's loss of vertebral height of 40% was related to her fall at work and was permanent. RX1 at 19, 23. He also acknowledged that when the mechanics of the spine are changed, it can change the stresses elsewhere in the spine. *Id.* Dr. Lami reviewed Dr. Siodlarz's note of June 26, 2013 in which he diagnosed Petitioner with traumatic T10 intercostal neuralgia and a left T10 fracture. *Id.*, at 21. He acknowledged that misalignment of a fracture could stress adjacent levels. *Id.*, at 21-22. Dr. Lami also explained that kyphosis is a forward-going spinal curvature and that Petitioner's fall at work and loss of vertebral height could have caused her kyphosis. *Id.*, at 26-27.

Additional Information

Since the workplace accident, Petitioner testified that she can only sleep on her right side and she wakes up several times throughout the night. She explained that she cannot garden, be on her knees or sit, and she has to stand up at work or bend over and often reposition in order to relieve pressure. Petitioner also testified that she cannot ride her bike the same way and she has difficulty cleaning and normally executing household or laundry activities. Petitioner explained that she never had back pain or such issues prior to her injury at work. She described her pain and symptoms such that she feels like the bone is sticking through her back and she experiences pain when breathing.

Petitioner testified that she was unable to work in her position for Respondent for a period of time as restricted by her physicians. She explained that her restrictions would not allow her to do her regular job for Respondent. On cross examination, Petitioner explained that, while working for Respondent, she had another job working for Dr. Larsen, a neurologist, as a medical biller. The position was sedentary and she submitted insurance claims and spoke with insurance companies. She did miss time from work with Dr. Larsen, but also had a customer service representative job at a veterinary office in which she performed sedentary activities such as answering phones. She did not lift the animals. Petitioner testified that she wishes to undergo the recommended medical treatment.

ISSUES AND CONCLUSIONS

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

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

In light of the record as a whole, the Arbitrator finds that Petitioner has established causal connection between her current condition of ill-being in the mid and low back and her accident at work. In so concluding, several facts are significant.

Petitioner had no complaints or medical treatment relative to the mid or low back before her accident at work. She only became symptomatic immediately after her 5-6 foot fall from a ladder at work prompting emergency room care with subsequent medical treatment and, ultimately, the recommendation for pain management including a nerve root blockade currently in dispute. There is no evidence that Petitioner's complaints pre-existed her accident at work. Indeed, the symptoms that Petitioner immediately reported after her accident were thereafter consistently reported to emergency room, treating, and evaluating physicians alike.

Petitioner's October 16, 2012 MRI shows an acute compression fracture of T12 and signal changes in the anteroinferior portion of T11 was secondary to chronic degenerative disc disease. Petitioner underwent care with several physicians thereafter, but primarily with Dr. Siodlarz and Dr. Sokolowski. As of June 23, 2013, Dr. Siodlarz diagnosed Petitioner with traumatic left T10 intercostal neuralgia, left T10 fracture and a chronic T12 vertebral fracture. Petitioner also sought treatment with Dr. Sokolowski. As of December 31, 2014, after two injections provided Petitioner with short-term pain relief, Dr. Siodlarz recommended a third thoracic epidural steroid injection. Petitioner underwent this injection, again with only limited pain relief. She then continued medical treatment with Dr. Sokolowski. As of her last visit with Dr. Sokolowski on June 22, 2015, he noted that Petitioner's symptoms at the thoracolumbar junction were increasing and he noted her continued, radiating left T12 intercostal nerve pain.

Dr. Sokolowski ordered pain management including a nerve root blockade, which he indicated was directly related to her injury at work. Petitioner also underwent several medical evaluations with Dr. Lami at Respondent's request. Dr. Lami agreed that Petitioner's physical condition was causally related to her accident at work and that her subjective complaints were also related to the accident. Dr. Lami and Dr. Sokolowski part ways with regard to whether Petitioner should receive any continued pain management or injections. Both physicians were deposed. After careful consideration of the physicians' opinions and their bases, the Arbitrator finds the opinions of Dr. Sokolowski to be more persuasive in this case.

Dr. Sokolowski testified that Petitioner's continued to have pain and symptoms related to her fall at work. He also explained that the deterioration of Petitioner's spine resulted from the fracture caused by her fall from the ladder at work. At his deposition, Dr. Lami testified on direct examination, as is also reflected in his reports, that Petitioner's fall at work caused an acute fracture at T12 and that her subjective complaints were causally related to the fall at work from a chronological standpoint. He acknowledged that Petitioner had no symptomatic pre-existing condition in the spine and he found no indication that Petitioner's subjective complaints were contrary to objective medical evidence. While Dr. Lami did not believe that Petitioner's multi-level disk degeneration was related to the accident at work, he explained only that it was a cause of her pain and

symptoms, but not the only cause.

In light of the totality of the evidence, the Arbitrator finds the opinions of Petitioner's treating physician, Dr. Sokolowski, to be more persuasive than those of Dr. Lami in this case. Dr. Sokolowski plausibly explained that the mechanism of Petitioner's injury was competent to cause the type of ongoing pain and symptoms that she continues to experience and he highlighted the lack of prior spinal injuries, pain, or medical treatment. Dr. Lami agrees. There is no evidence from any of the physicians to suggest that Petitioner is malingering, exaggerating or suffering from continued symptoms stemming from the same area of the spine as the sole result of pre-existing degeneration. Dr. Lami also agrees—he simply would not recommend further medical treatment beyond medication management.

Given the record in light of the foregoing, the Arbitrator finds the opinions of Dr. Sokolowski to be more persuasive than those of Dr. Lami in this case and, given the totality of the medical evidence in this record, the Arbitrator finds that Petitioner has established causal connection between her current mid and low back condition and her accident at work.

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

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992)). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

As explained more fully above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her accident at work relying on Petitioner's testimony which is corroborated by the medical records as well as the recommendations and opinions of her treating physician, Dr. Sokolowski. The medical bills submitted into evidence are for the reasonable and necessary medical treatment rendered to Petitioner to address her ongoing condition as a result of her fall at work. Accordingly, the Arbitrator finds that the medical bills submitted into evidence by Petitioner that remain unpaid, or which were paid out-of-pocket by Petitioner, are to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit, if any, as agreed by the parties.

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

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her accident at work as claimed. Petitioner's mid and low back symptoms have not improved after her accident as reflected in the medical records and explained by Petitioner's treating physician, Dr. Sokolowski. In consideration of the record as a whole, the Arbitrator awards the recommended prospective medical care in the form of pain management including a nerve root blockade as prescribed by Dr. Sokolowski pursuant to Section 8(a) of the Act as these treatments are reasonable and necessary to alleviate Petitioner from the effects of her

injury at work.

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

In light of the causal connection analysis explained above, the Arbitrator addresses Petitioner's claim that she is entitled to temporary partial disability benefits from October 9, 2012 through January 1, 2013 and April 25, 2013 through May 16, 2013.

The Illinois Workers' Compensation Act (Act) provides for temporary partial disability benefits in certain circumstances. "When the employee is working light duty on a part-time basis or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job or jobs, then the employee shall be entitled to temporary partial disability benefits. Temporary partial disability benefits shall be equal to two-thirds of the difference between the average amount that the employee would be able to earn in the full performance of his or her duties in the occupation in which he or she was engaged at the time of accident and the gross amount which he or she is earning in the modified job provided to the employee by the employer or in any other job that the employee is working." 820 ILCS 305/8(a) (LEXIS 2011).

The record reflects that during the claimed temporary partial disability periods Petitioner was under light duty work restrictions as imposed by her treating physicians, which were not or could not be accommodated by Respondent. No evidence was submitted to suggest that Petitioner was able to work during the claimed temporary partial disability period beyond what she was able to do within her restrictions working for other employers. Thus, the Arbitrator finds that Petitioner has established that she was temporarily partially disabled during the claimed periods as a result of her injury at work.

The parties stipulated that Petitioner earned an average weekly wage of $388.83 including both of her jobs at the time of her workplace injury. AX1. However, Petitioner submitted no evidence regarding her earned wages during the disputed temporary partial disability periods and whether she earned less than she would have been earning in the full capacity of her jobs at the time of her injury such that the appropriate temporary partial disability benefits may be calculated. Based on the foregoing, the Arbitrator finds that Petitioner has failed to establish her entitlement to temporary partial disability benefits from October 9, 2012 through January 1, 2013 and April 25, 2013 through May 16, 2013 as claimed.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lynn Luloh,

Petitioner,

18IWCC0189

vs.

NO: 17 WC 04583

Federal Express,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, and medical expenses and being advised of the facts and law, reverses the Decision of the Arbitrator which is attached hereto and remands this case to the Arbitrator for further proceedings pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Petitioner, a 59-year-old courier, alleged she sustained a work-related injury to her left knee on November 30, 2016. On that date, Petitioner was performing her normal ~~job~~ duties. After making a delivery, she turned to her left to return to her truck. Petitioner testified that her left foot stayed planted on the ground and her left knee twisted. She testified that she noticed her knee hurting as she walked back to her truck. Petitioner testified that she did not know why her left foot did not turn with her body; there was nothing abnormal about the ground. Respondent denied Petitioner's claim for benefits under the Act on the basis that Petitioner's injury did not arise out of her employment. At the §19(b) hearing, Petitioner sought an award of medical expenses, prospective medical care, and temporary total disability benefits.

In a §19(b) Decision dated September 5, 2017, the Arbitrator found that Petitioner's injury did not arise out of any risk associated with her employment and the Arbitrator denied Petitioner's claim for

benefits. Petitioner timely appealed the Decision of the Arbitrator. After considering all the evidence, we reverse the Decision of the Arbitrator as set forth below.

The facts of the case are not in dispute. Petitioner has been a FedEx courier for 20 years. She delivers 70 to 100 packages per day. Petitioner testified that her injury occurred during a normal delivery. At the time of the occurrence she was not carrying anything, she was not in an unusual hurry, and there was no defect on the ground. Petitioner's status as a "travelling employee" is also undisputed. A travelling employee is one who is required to travel away from the employer's premises for work. In Illinois, an injury to a travelling employee arises out of employment if the conduct in which the employee was engaged at the time was reasonable and normally anticipated or foreseen by the employer.

We find that Petitioner's injury arose out of her employment. It is undisputed that at the time of the accident Petitioner was performing acts essential to her employment. To deliver packages and return to the truck, Petitioner must bend, rise, and turn as necessary. Bending, rising, and turning are acts performed by the public, but for Petitioner these acts are integral to the essential duties of her job. Furthermore, her conduct at the time of the injury was reasonable and was conduct that was anticipated or foreseeable as she was on-duty and in the process of making her deliveries.

Petitioner relied on the Appellate Court case *Mytnik v. IWCC* 2016 IL App (1st) 152116WC, 409 Ill. Dec. 491, 67 N.E. 3d 946. In *Mytnik,* a claimant injured his low back bending down to pick up a fallen bolt. The Appellate Court found that it was an integral part of the claimant's job to quickly pick up fallen bolts before they caused problems with the machinery, even if the act of bending over may be an act performed by the public daily. The Appellate Court found that the risk the claimant was exposed to was not a neutral risk and was instead incidental to his employment, belonging to or connected with what an employee must do to fulfill his duties. Petitioner also cited *Young v. IWCC* 2014 IL App (4th) 130392WC, 383 Ill. Dec. 131, 13 N.E. 3d 1252, which is explained in *Mytnik.* In *Young*, the claimant was a parts inspector whose job was to reach into a box and pull out parts to examine. The claimant felt a snap or pop in his shoulder as he was reaching for the last item in the box. The Appellate Court found that the risk to which the claimant was exposed was necessary to the performance of his job duties at the time of his injury. We agree with Petitioner that *Mytnik* and *Young* are analogous to the case at hand.

Petitioner gave consistent histories of the mechanism of injury to medical providers at First Choice Occupational Health and to Respondent's workers' compensation insurance adjustor investigating the claim. Petitioner eventually came under the care of Dr. Karlsson, an orthopedic surgeon at DuPage Medical Group. On February 10, 2017, Dr. Karlsson examined Petitioner and reviewed her left knee MRI. Dr. Karlsson diagnosed osteoarthritis, a medial meniscus tear, and avascular necrosis. Dr. Karlsson took Petitioner off work for approximately one month. Petitioner returned to Dr. Karlsson on March 10, 2017 and underwent a Lidocaine-DepoMedrol injection. The records of Dr. Karlsson show that Petitioner wished to discuss surgical options, but Dr. Karlsson recommended treating conservatively at the time. Petitioner did not return to Dr. Karlsson after March 10, 2017. She testified that she is working full duty and her left knee feels "alright."

On April 24, 2017 Petitioner was examined by Dr. Tonino at the request of Respondent pursuant

to §12. Dr. Tonino is an orthopedic surgeon at Loyola University Medical Center. Petitioner gave a consistent history of the injury and she reported that an injection improved her symptoms. Dr. Tonino opined that Petitioner's accident could be a competent cause of left knee "symptoms." He stated that he would like to further evaluate the medial femoral condyle lesion previously seen on the February 2017 MRI with follow-up imaging. Therefore, we remand this case to the Arbitrator for further proceedings on the issues of causal connection for prospective medical treatment and a further amount of temporary total disability benefits or compensation for permanent disability, if any.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $718.73 per week for a period of 6 5/7 weeks, that being the stipulated duration of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $3,300.16 for group disability benefits paid to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner's reasonable and necessary medical expenses incurred in the diagnosis and treatment of Petitioner's left knee injury of November 30, 2016 pursuant to §8(a) and 8.2 of the Act. Respondent is entitled to credit for payment of medical bills paid by the Respondent or group health carrier in this case under §8(j) 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $47,000. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 28 2018
DLS/plv
o-3/1/18
46

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0189

LULOH, LYNN
Employee/Petitioner

Case# **17WC004583**

FEDERAL EXPRESS
Employer/Respondent

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:

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

2912 HANSON LAW OFFICES LTD
KURT HANSON
6040 STATE ROUTE 53 SUITE B
LISLE, IL 60532

18IWCC0189

STATE OF ILLINOIS)
)SS.
COUNTY OF Dupage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Lynn Luloh
Employee/Petitioner

Case # **17** WC **4583**

v.

Consolidated cases: _____

Federal Express
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Wheaton**, on **June 28, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0189

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 not* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$56,060.68**; the average weekly wage was **$1,078.09**.

On the date of accident, Petitioner was **59** years of age, *single* with **0** dependent children.

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$3,300.16** for other benefits, for a total credit of **$3,300.16**.

Respondent is entitled to a credit of **$3,300.16 for group disability benefits and the parties stipulate that the Respondent is entitled to a credit for payment of medical bills paid by the Respondent or Group Health Carrier in this case** under Section 8(j) of the Act.

ORDER

Because the Petitioner's alleged injuries did not arise from a risk associated with the employment by Respondent, the injuries did not arise out of the employment. Accordingly, all benefits are denied.

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

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

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

Jason C. Mozuty

Signature of Arbitrator

8/30/17
Date

ICArbDec19(b)

SEP - 5 2017

STATE OF ILLINOIS)
)
COUNTY OF DUPAGE)

18IWCC0189

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LYNN LULOH
Petitioner,
vs.
FEDERAL EXPRESS,
Respondent.

17 WC 4583

ADDENDUM TO THE DECISION OF THE DECISION OF ARBITRATOR

This matter proceeded to hearing on June 28, 2017 in Wheaton, Illinois. (Arb. 1). The following issues are in dispute: accident, causal connection, unpaid medical bills, TTD, and prospective medical benefits. (Id.).

FINDINGS OF FACT

The fifty-nine-year old Petitioner has been employed with the Respondent, Federal Express, for approximately twenty-years as a courier. Her duties include delivery of approximately seventy-to-hundred packages each day over a time frame of six-to-eight-hours.

The Petitioner testified that on November 30, 2016, while dropping a package onto the recipient's doorstep, she turned to her left when her left foot did not turn with her and as she swung her right leg around, her left knee "twisted". She completed her shift on that date, and reported the incident to her supervisor the next morning, after which she completed her work shift.

The Petitioner was first seen for medical treatment on December 1, 2016, at First Choice Occupational Health, who noted complaints of left knee swelling. (Pet. Ex. 1) The Petitioner reported a history of delivering a package and twisted her left knee. She denied any prior left knee problems. A diagnosis of a left knee sprain and effusion was noted, work restrictions were instituted and Petitioner was instructed to follow-up on December 5, 2016. (Id.). When she returned on December 5, 2016, Petitioner reported her complaints of left knee pain were at a 0/10 and that she had returned to her regular work duties earlier that morning. (Id.)

The Petitioner testified that she returned to regular duty as it was the Respondent's "peak season", during which she worked a significant amount of overtime.

The Petitioner provided a recorded statement to Respondent on December 9, 2016, at which time she reported putting a package down on a doorstep, turning her body but her "one foot didn't follow" her. (Res. Ex. 1) Her left foot stayed on the ground, and "didn't kinda move with me". She then felt a twist in the left knee. Petitioner further stated that "maybe I didn't pick up my foot, I don't know what I did". (Id.)

The Petitioner reported for follow-up treatment on February 1, 2017 with her personal care physician, Dr. Yayati Patel, who noted complaints of chronic left knee pain. By history, Petitioner reported an onset two-months prior, with a twisting injury. The doctor noted a diagnosis of chronic left knee pain. (Res. Ex. 2)

The Petitioner was scheduled for a left knee MRI, and later presented for orthopedic consult with Dr. Troy Karlsson at Dupage Medical Group on February 10, 2017. (Pet. Ex. 2). She reported a history of a twisting injury at work. She denied any prior history of left knee problems. Dr. Karlsson reviewed the MRI study, noting a medial meniscus tear and degenerative changes. The MRI was confirmed by x-ray revealing severe patellofemoral arthritis. Diagnosis was osteoarthritis, medial meniscus tear and AVN. The Petitioner returned to Dr. Karlsson on March 10, 2017, with persistent left knee complaints. (Id.). The doctor noted Petitioner was "wondering what further treatment is, even asking about total knee replacement". (Pet. Ex. 2) An injection to her left knee was administered and the doctor noted tentative left knee arthroscopy to be scheduled. (Pet. Ex. 2)

The Petitioner was seen for an Independent Medical Evaluation with Dr. Pietro Tonino on April 24, 2017. By history, she reported that she put down a package at someone's house, turned, and her foot stayed while her upper body twisted". She reported that she had undergone and injection and was feeling better. Dr. Tonino diagnosed left knee chondromalacia, medical meniscus tear status post-subchondral fracture and medial femoral condyle. Dr. Tonino felt that the Petitioner's reported mechanism of injury, involving a twisting of the left knee, could be a consistent cause of left knee symptoms. Dr. Tonino recommended a follow-up left knee MRI to evaluate healing of the medial femoral condyle lesion. He noted Petitioner could continue her normal work duties. (Res. Ex. 4)

At arbitration, the Petitioner initially denied any prior left knee issues, but later advised of an injury suffered previously when she fell on a boat. Medical records from Elmhurst Health confirm the injury to the Petitioner's left knee after a fall in 2007. (Pet. Ex. 3)

The Petitioner did not attribute the injury to being in a hurry although she did testify that Respondent does have expectations regarding the time required to deliver packages and failure to meet those expectations could result in reprimands.

The Petitioner testified further that she had not returned for any additional medical treatment since March 10, 2017, and had no visits scheduled. While she was continuing to work her regular work duties, she indicated that she would like to obtain additional treatment.

The Parties stipulated that the Petitioner was temporarily and totally disabled for a period of 6 6/7-weeks against which the Respondent had an available credit for group disability payments totaling $3,300.16. The parties further stipulated that the medical bills in this case have been paid by the Respondent or the Respondent's group health carrier, for which the Respondent is entitled to a credit.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision with respect to (C) Did an accident occur that arouse out of and in the course of Petitioner's employment by Respondent?, the Arbitrator finds and concludes the following:

The Petitioner in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all elements of his claim, including proof that he suffered an accident which arose out of and in the course of his employment by Respondent. (*Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Commission*, 407 Ill.App.3d 1010, 1013 (2011)

Injuries sustained at a place where a Petitioner might reasonably have been while performing his work duties are deemed to have been received in the course of his employment. (*Caterpillar Tractor Company v. Industrial Commission*, 129 Ill.2d 52, 57 (1989) In this case, it is undisputed that the Petitioner was in the course of her employment by Respondent as she was performing her duties as a courier by delivering a package.

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. (*Caterpillar Tractor Company v. Industrial Commission*, at 58) There are three general types of risk to which an employee may be exposed; (1) risks that are distinctly associated with the employment, (2) risks that are personal to the employee, (3) neutral risks that do not have any particular employment or personal characteristics. (*Potenzo v. Illinois Workers' Compensation Commission*, 378 Ill.App.3d 113, 116 (2007)

In this case, the Petitioner twisted her left knee while turning. It is undisputed that the Petitioner's left foot simply did not move with her when she turned. The Petitioner was not carrying anything when she turned, nor did she identify any defects on the ground that caused her left foot not to move. Further, while the Petitioner testified that she must make her deliveries on a timely basis, she provided no evidence that her left foot did not turn with her because she was in a hurry, nor did she provide any evidence that she performed the particular act of turning to her left in a repetitive manner throughout the workday.

As such, there is no evidence that the risk of turning was directly associated with her employment, nor may the risk be deemed as a neutral risk. The risk in this case appears personal to the Petitioner.

The Petitioner in this case may be considered a traveling employee, to which different rules may govern the determination of compensability. However, the fact that a Petitioner is a traveling employee does not relieve her of the burden of proving that her injury arose out of her employment. (*Hoffman v. Industrial Commission*, 109 Ill.2d 194, 199 (1985)

Injuries that may be considered personal risk may not be considered as compensable under the Act. Even with an injury considered as a neutral risk, a traveling employment may still be exposed to that risk to a greater degree than the general public. (*Illinois Institute of Technology Research Institute v. Industrial Commission*, 314 Ill.App.3d 149, 163 (2000)

The increased risk may be either qualitative, when some aspect of the employment contributes to the risk, or quantitative as when the employees exposed the risk more frequently than the general public. (*Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill.App.3d 1014

In this case, there is no evidence that the Petitioner's employment contributed to the risk of her left foot not moving or sticking when she turned. Again, there is no evidence that the Petitioner was carrying anything, or that there was any defect on the ground, or was turning in haste. There is nothing in the record to distinguish the Petitioner's turn at work, with the left foot not moving, causing it to twist, from any other similar movement outside of her employment.

Accordingly, the Petitioner's injury did not arise out of her employment by the Respondent. Based upon the foregoing, and having considered the totality of the credible evidence, the Arbitrator finds that the Petitioner failed to provide an accident occurred which arose out of her employment by Respondent. The Petitioner's claim for compensation is hereby denied.

In light of the Arbitrator's findings and conclusions with regards to the issue of accident, all other issues are considered 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

Rodney Smith,
Petitioner,

18IWCC0190

vs.

NO: 08 WC 2521

Rock Solid Paving & Excavating Co. and
IL State Treasurer Ex-Officio Custodian of the
Injured Workers' Benefit Fund,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, date of accident, nature and extent, medical, causal connection, notice, jurisdiction 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 25, 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:
o3/22/18
DLS/rm
046

MAR 28 2018

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

18IWCC0190

SMITH, RODNEY
Employee/Petitioner

Case# **08WC002521**

ROCK SOLID PAVING & EXCAVATING CO AND ILLINOIS STATE TREASURER EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 4/25/2017, 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 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.

2399 SILVERMAN, CLIFFORD A
18311 N CREEK DR
SUITE G
TINLEY PARK, IL 60477

1739 STONE & JOHNSON CHARTERED
PATRICK DUFFY
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

5875 ASSISTANT ATTORNEY GENERAL
STEPHANIE KEVIL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

18IWCC0190

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☒ 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

Rodney Smith
Employee/Petitioner

v.

Rock Solid Paving & Excavating Co. and Illinois State Treasurer, Ex-Officio Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

Case # **08** WC **02521**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **July 25, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 21, 2007**, Respondent employer ***was not*** operating under and subject to the provisions of the Act.

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 **37** years of age, ***married*** with **8** dependent children.

ORDER

Petitioner did not sustain an accidental injury in Illinois on November 21, 2007. As such, any injury sustained on that day is not within the jurisdiction of the Illinois Workers' Compensation Act. Therefore, the Arbitrator denies benefits under the Act. All other disputed issues have been rendered moot.

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

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

Signature of Arbitrator

April 25, 2017
Date

APR 25 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rodney Smith, Petitioner, v. Rock Solid Paving & Excavating Co., and the Illinois State Treasurer, Ex-Officio Custodian of the Injured Workers' Benefit Fund, Respondent.	)	Case No. 08 WC 02521

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Findings of Fact

Rock Solid Paving & Excavating Co. ("Rock Solid") was an asphalt paving company. Hugh Graham testified that he was the president of Rock Solid. He and his wife each owned 50%. It is a seasonal business. During the winter months, they plow snow. In 2007 Rock Solid had about 22 employees. They are located in St. John, IN.

Beginning in 2005 until sometime after the alleged accident date, Rodney Smith ("Petitioner") worked as a truck driver for Rock Solid. In the winter he plowed snow when needed. Petitioner's attorney stipulated that the site of Petitioner's employment contract with Rock Solid was Indiana. He was paid hourly. He completed timesheets. Information included on his timesheet included the job site and the hours. RX 2 is a set of his timesheets for 2007.

Petitioner testified that on November 21, 2007, he drove a dump truck and picked up asphalt for the employer. On that date he started work between 9:00 and 10:00 a.m. He dropped off a paver at a work site in Valparaiso, IN, but did not recall the time. He was told to do so by Hugh Graham. Graham then told him to pick up asphalt. Petitioner drove to pick up and to drop off the asphalt. After dropping off the asphalt, he returned the excess asphalt to the yard. Petitioner further testified that he returned to the Valparaiso job site, hooked up the trailer and paver to the truck, and drove to Richton Park, IL. He could not recall when he was told to take the paver to Richton Park. At first, he could not recall if Neil or Graham directed him to go to Richton Park. He then remembered that Graham told him to go to Rich South High School in Richton Park. He could not recall when he went to Richton Park that day, but that he might have gotten there around noon to 1:00 p.m.

When he arrived at Rich South H.S., Petitioner testified, he had to help unload the paver. To unload the paver, it is necessary to extend the two ramps on the trailer down to the pavement. Each ramp is made of steel, is about six to seven feet long, and weighs between 80 and 100 pounds. Neil was at the site. Petitioner had no problem unloading the paver. He then waited for his co-workers to complete their use of the paver.

When his co-workers finished using the paver, they put it back on the trailer. Petitioner testified that he then lifted the first ramp and felt right shoulder pain. Petitioner dropped the ramp. Neil told him to "quit being a pussy." Neil then lifted both ramps. Petitioner then drove the truck that hauled the paver to the yard.

When he returned to the yard, Petitioner testified, he told Hugh Graham that he hurt his shoulder. Petitioner said to Graham that he was going to the doctor and to get it checked out. Graham agreed that he should do that.

Hugh Graham testified as an adverse witness in Petitioner's case and as a witness in Rock Solid's case. Graham agreed that on November 21, 2007, Petitioner was an employee of Rock Solid. He was paid hourly wages and taxes were withheld. He is not related to Petitioner. He thought Petitioner was a nice young man, respectful and a good employee. He never questioned Petitioner's trustworthiness or loyalty. Graham testified that at that time, they had a job at Rich East High School, not Rich South High School. Graham identified his signature on PX 9, which was a contract between the employer and Rich South High School. Rich South High School is located in Richton Park, IL. Graham did not recall when the project at Rich South High School began or ended.

Graham testified that he was on the job site in Valparaiso on November 21, 2007 and Petitioner did not haul the paver on that day. He testified that Neil was in Valpo and not at Rich South on that day. Graham testified that his lowboy driver towed the paver to Valparaiso on November 21, 2007. He testified that Petitioner was not typically allowed to use the trailer for anything because of his previous shoulder injury. He testified that Neil was not at the Rich South job site on November 21, 2007. He testified that Petitioner used the trailer on November 20, 2007, but that someone was with him that day to help with the ramps. Graham further testified that in Petitioner's timesheet of November 20, 2007, Petitioner wrote that he hauled the paver because that was not his usual job. He did not think Petitioner took the paver to Richton Park on November 21, 2007. He had no doubt that Petitioner worked on November 24, 2007 at Valparaiso, IN and at Richton Park, IL.

Petitioner did not offer PX 9 into evidence.

Graham disagreed with Petitioner's testimony that Petitioner told him about the accident on November 21, 2007. He testified that he first learned of the alleged accident in January 2008. He identified the First Report of Accident, prepared on January 4, 2008. After he learned about the alleged accident, he asked Neil how Petitioner got hurt. He asked Neil if Petitioner got hurt on site, and Neil responded "no."

Graham himself had undergone bilateral shoulder surgery. He and Petitioner used to discuss their shoulder injuries. He speculated that Petitioner has confused these conversations with providing notice of a November 21st accident to Graham.

Petitioner's attorney referred to a Third Amended Application wherein he claimed a November 24, 2007accident.

On redirect examination, Petitioner was adamant that he hurt his shoulder on a weekday. Petitioner then testified that on the handwritten timesheets (PX 2), he forgot to include in the November 21, 2007 entry that he drove the paver to the job site in Richton Park, IL, that afternoon.

On recross examination, Petitioner testified that he was required to fill out timesheets for Rock Solid and would be paid for all the hours recorded. Petitioner further testified that it would be in his best interest to write down all of the hours that he worked.

In rebuttal, Petitioner testified that he told Graham about the accident on the same day as the accident whether that was on November 21st or November 24th, 2007. The discussion took place at the Rock Solid yard in Valparaiso, IN.

Rock Solid had a policy to report accidents immediately. An injured employee was to notify Graham or go to the office and notify Anna Gollner, a secretary at Rock Solid. Graham testified that employees were instructed as to this policy and were to provide immediate notice of any accident.

RX1 is the "Indiana Worker's Compensation First Report of Employee Injury, Illness." The report is dated "January 4, 2007". However, it was prepared on January 4, 2008. Petitioner was given that form on that date by Anna Gollner from Respondent. RX 1 indicates that the report was prepared by Rodney Smth/Anna Gollner. RX 1 also indicates that Petitioner sustained a right shoulder injury on November 21, 2007, when he felt a painful pinch while lifting ramps on a trailer at Rich South High School in Richton Park, IL. In the INITIAL TREATMENT section, the form displays a question mark, but also shows a check mark in the box beside "Emergency Care."

Petitioner testified that he did seek emergency care after he sustained the injury, but he did recall where.

On redirect examination, Petitioner testified that on RX 1, he did not check the box beside Emergency Care.

The first known medical date of service following the alleged accident was on January 8, 2008 with Dr. Mehl. On that date, Petitioner associated his injury with a November 21, 2007 accident.

PX 2 indicates that on November 21, 2007, Petitioner worked in Valparaiso, IN, and on November 24, 2007, he worked at Rich East High School in Richton Park, IL, and on Shagbark Lane in Valparaiso, IN.

Petitioner continued to work after the date of accident. He worked 6 days the following week and on December 4th and 5th. He was then laid off for the season but worked several days later in the month plowing snow. He applied for unemployment compensation with the State of Indiana on December 7, 2007. When he applied for unemployment compensation, he represented to the State that he was able to work.

Petitioner testified that following November 21, 2007, the first medical treatment he received was on January 8, 2008. Petitioner testified that he had to wait to see Dr. Mehl because he is a specialist. Dr. Mehl had performed surgery on Petitioner's right shoulder in March of 2007. After his January 8, 2008 office visit to Dr. Mehl, Petitioner underwent an MRI. He then switched his care to Dr. Nicole Einhorn, another orthopedic surgeon. He did not know why he switched his care to Dr. Einhorn.

Dr. Mehl performed surgery on May 30, 2008. Petitioner then underwent physical therapy. On December 16, 2008 Dr. Einhorn performed another surgery followed by physical therapy. He was released to return to work without restriction on February 25, 2009. (PX 5)

Currently, Petitioner works as a semi-truck driver. At the end of the day his arm hurts. The pain in his shoulder is activity-dependent; i.e., the more he does, the greater his symptoms. Petitioner testified that he did not work in 2009 or 2010. In 2013, he worked in a railyard moving containers. In 2014, he started working as a semi-truck driver.

On direct examination, Petitioner testified that before November 21, 2007, he never injured his right arm. He did not recall having right shoulder pain as early as 1999. He agreed that if Dr. Kim's records reflect complaints of right shoulder pain in 1999, such records would be accurate.

RX 6 shows that Petitioner had an MRI of the right shoulder on February 16, 2001 and RX 7 shows he had another MRI of the right shoulder on February 16, 2007. Dr. Mehl performed right shoulder surgery on March 20, 2007.

Petitioner testified that he did not file a claim for the onset of right shoulder symptoms in February 2007.

Petitioner acknowledged having a motor vehicle accident while plowing snow in December 2007, but denied hurting his right shoulder in such MVA.

In a Circuit Court Order entered on April 28, 2016, Judge Kathleen M. Pantle wrote:

> "Rock Solid does not dispute that it learned of Smith's accident at or near the time it occurred in November 2007 or that it knew of the claim shortly after it was filed in January 2008." (PX 7)

Conclusions of Law

In support of his decision with regard to issues (A) "Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?", and (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", the Arbitrator concludes:

The Illinois Workers' Compensation Commission's jurisdiction is governed by Section 1(b)(2) of the Act, which states the following:

1(b): Employee

(b) The term "employee" as used in this Act means: ***

Jurisdiction

2. Every person in the service of another under any contract of hire, express or implied, oral or written, including persons whose employment is outside of the State of Illinois where the contract of hire is made within the State of Illinois, persons whose employment results in fatal or non-fatal injuries within the State of Illinois where the contract of hire is made outside of the State of Illinois, and persons whose employment is principally localized within the State of Illinois, regardless of the place of the accident or the place where the contract of hire was made, and including aliens, and minors who, for the purpose of this Act are considered the same and have the same power to contract, receive payments and give quittances therefor, as adult employees.

In Robert C. Mahoney v. Indus. Comm'n, 218 Ill. 2d 358 (2006), the Supreme Court held that the site of the contract for hire is the sole determining factor in ascertaining the applicability of the Illinois Workers Compensation Act to a work injury that occurs outside of the state of Illinois.

Petitioner's attorney stipulated that Petitioner was hired in Indiana. Consequently, if the accident did not occur in Illinois, the Illinois Workers Compensation Act does not apply to this alleged accident.

In his initial Application for Adjustment of Claim, Petitioner alleged that the accident occurred on November 21, 2007. He completed an Indiana First Report of Injury wherein he stated that the accident occurred on November 21, 2007. He then told Dr. Mehl and his other treating physicians that the accident occurred on November 21, 2007.

Petitioner, on the date of Arbitration, submitted the Request for Hearing form in which he claimed an accident date of November 21, 2007. (AX 1)

The language of Section 7030.40 [of the Rules] indicates that the request for hearing is binding on the parties as to the claims made therein. Walker v. Indus. Comm'n, 345 Ill. App. 3d 1084 (4th Dist. 2004)

The Arbitrator notes that with the exception of minor changes, the language in Section 9030.40 of the amended Rules is the same as the language in Section 7030.40 of the old Rules.

Petitioner testified at Arbitration that the accident occurred on November 21, 2007.

On redirect examination, when Petitioner's attorney suggested that the accident may have occurred on Saturday, November 24, 2007, Petitioner insisted that it occurred on a weekday.

Petitioner's timesheet for November 21, 2007 reflects that Petitioner only worked in Valparaiso, IN. on November 21, 2007. (PX 2)

The Arbitrator places significant weight on PX 2, which is the set of Petitioner's timesheets for the time period April 24, 2007 through December 5, 2007. After a close inspection of PX 2, the Arbitrator notes that for each date worked, Petitioner always recorded the date, the hours and the location or locations. Frequently, he would also record the activity or activities he performed that day. For November 21, 2007, Petitioner wrote that he worked in "Valpo, IN" from 5:30 AM to 10:30 AM for a total of 5 hours. For November 24, 2007, Petitioner wrote that he worked at "Rich East High School" in "Richton Park, IL" as well as at a "House" on "Shagbark Lane" in "Valpo, IN" from 8:00 AM to 3:45 PM for a total of 7.75 hours.

The Arbitrator places significant weight on PX 2 because (1) the information on the timesheets was recorded contemporaneously with the work performed and (2) such information was recorded by Petitioner's own hand. For both of these reasons, the Arbitrator finds PX 2 to be reliable.

The Arbitrator is not convinced by Petitioner's testimony on redirect that he forgot to include in the November 21, 2007 entry that he drove the paver to the job site in Richton Park, IL, that afternoon. The Arbitrator reasons that as Petitioner was being paid by the hour, it is unlikely that he would forget to include all of his hours.

After November 21, 2007, there is no documentary evidence as to any alleged accident until the Indiana Report was completed 6 weeks later. On January 4, 2008, Petitioner and Anna Gollner prepared the "Indiana Worker's Compensation First Report of Employee Injury, Illness" wherein he claimed an accident date of November 21, 2007 and an accident location of Rich South High School in Richton Park, IL. (PX 8, RX 1)

At no time prior to January 4, 2008 did Petitioner represent that he was unable to work.

Neil no longer works for Rock Solid. There is no evidence that Neil lives in the state of Illinois.

There is no evidence that either party attempted to secure Neil's testimony.

Petitioner's testimony regarding his conversation with Neil on November 21, 2007 stands unrebutted.

Petitioner testified on direct examination that before November 21, 2007, he never injured his right arm.

On cross-examination by Stephanie Kevil, Petitioner testified that it is not possible that he injured his right shoulder before 2007. On cross-examination by Patrick Duffy, Petitioner testified that he did not recall seeing Dr. Kim for his shoulder on June 17, 1999.

Dr. Kim's chart notes of June 17, 1999 reflect, in pertinent part, the following:

> "This 28 yr. old male, one of Dr. Ravanam's pt.'s came in with painful right shoulder for 6 weeks. The pt. stated that he was doing work out and lifting weights and developed right shoulder pain. He was not doing weight lifting any more, however, there was persistent pain in the right shoulder. The pt. was prescribed Naprosyn and Flexeril around a month ago and pt. stated it did not help much." (RX 5)

Subsequently, on March 12, 2007, Dr. Mehl recorded, in pertinent part, the following:

> "Rodney is previous patient of mine who I had fixed his left shoulder (sic) for rotator cuff. He now is having trouble with the right shoulder for several months. He does heavy-type work but does not recall any specific work injury. He had an MRI done a month ago showing a high-grade partial tear of the supraspinatus tendon, 8 mm. now, larger than from 2001 MRI. The AC joint shows impingement and degenerative disease." (PX 1)

On April 23, 2007, which was 5 weeks post arthroscopic right shoulder surgery, Dr. Mehl discharged Petitioner from therapy and from his care. At that time, Dr. Mehl also released Petitioner to return to work as a truck driver, effective April 24, 2007. (RX 8)

Based on the foregoing, the Arbitrator finds by a preponderance of the evidence that Petitioner did not sustain an accident in Illinois on November 21, 2007. Because an accidental injury did not occur in Illinois and because the site of the employment contract was not in Illinois, the Arbitrator finds that the Illinois Worker's Compensation Act does not apply here. Therefore, compensation is hereby denied. All other disputed issues have been rendered moot.

Rock Solid's attorney stated for the record that they paid $33,000.49 in TTD benefits to Petitioner, to which they are entitled a credit. Rock Solid's attorney also stated for the record that he spoke with a staff member at Dr. Nicole Einhorn's office and was told that there is a balance of $0.00 due from Petitioner for the treatment Dr. Einhorn rendered to him for his right shoulder condition.

Brian T. Cronin

Brian T. Cronin, Arbitrator

4-25-2017

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RONALD MERRITT,

Petitioner,

vs.

NO: 14 WC 32112
14 WC 36258

BOBBY MANN D/B/A TOPLESS TREE SERVICES,

Respondent.

18IWCC0191

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Petitioner and the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation, medical expenses, temporary disability, permanent disability, evidentiary rulings, and choice of doctors, 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.

I. 14 WC 36258

The Arbitrator found Petitioner failed to prove he sustained an accidental injury arising out of and in the course of his employment on May 23, 2014. While the Commission agrees Petitioner's May 23, 2014 injury is not compensable, a different analysis is required.

Petitioner testified Bobby Mann directed him to come to the company to pick up his paycheck. In *Gunthrop-Warren Printing Co. v. Industrial Commission*, 74 Ill. 2d 252, 384 N.E.2d 1318 (1979), involving a former employee killed while picking up his final paycheck, the Illinois Supreme Court held, for purposes of workers' compensation coverage, the employer-employee relationship persists for a reasonable time to enable the employee to collect his pay:

> The rule is stated succinctly by Professor Larson: "Compensation coverage is not automatically and instantaneously terminated by the firing or quitting of an

> employee." "The contract of employment is not fully terminated until the employee is paid, and accordingly an employee is in the course of employment while collecting his pay." (1A A. Larson, Workmen's Compensation secs. 26.10, 26.30, at 5 -- 228, 5 -- 240 (1978).) *Gunthrop-Warren Printing Co.*, 74 Ill. 2d at 257-58.

Pursuant to *Gunthrop-Warren*, Petitioner was in the course of his employment at the time of the altercation. Therefore, the analysis turns to whether the altercation arose out of his employment.

Compensability for injuries sustained during a physical confrontation at one's place of employment depends on the nature of the altercation. Where the fight is "a purely personal matter not growing out of a quarrel over the manner of conducting the employer's business," the resulting injuries to the disputants cannot be said to have arisen out of the employment; conversely, an injury in a fight between two employees "arising out of a quarrel concerning the employer's work in which they were engaged" is, for the non-aggressor, a risk incidental to the employment and therefore compensable. *Fisher v. Industrial Commission*, 408 Ill. 115, 119, 96 N.E.2d 478 (1951).

Petitioner testified that while he was waiting in the company lot to collect his paycheck, Travis approached his vehicle, asked if he had a case against Bobby, and when Petitioner responded no, Travis punched him in the face. This testimony, however, was stricken as hearsay. On review, Petitioner argues the statement of a supervisor adverse to the respondent is not hearsay and therefore, Petitioner's testimony established the dispute was related to work. The Commission agrees the testimony falls under the statement against party interest exception to the hearsay rule and was therefore improperly excluded. However, the Commission finds Petitioner failed to prove by a preponderance of the credible evidence that the altercation concerned the manner of conducting Respondent's business or Respondent's work in which they were engaged. Initially, the Commission observes Petitioner's medical records demonstrate he has anger management issues; this includes a documented instance of Petitioner making threats ("threatened that 'if you show me any more aggravation for a third time, the third time's a charm with Ron and you and I are going to have problems.'") As such, the Commission is not willing to simply accept Petitioner's testimony as to the impetus for the altercation. The Commission notes there were reportedly multiple witnesses to the confrontation, including employees of Respondent as well as the passenger in Petitioner's truck, yet no witness testimony was presented to corroborate who instigated the altercation. The Commission further observes a police report was apparently completed yet this was not offered into evidence. The Commission finds Petitioner's uncorroborated testimony is insufficient to prove the confrontation had its origin "in the employer's work in which they were engaged."

Although Petitioner was "in the course of" his employment, Petitioner failed to prove the subject of the confrontation was work-related and therefore the accident did not arise out of the employment. Therefore, the Commission finds Petitioner failed to establish he sustained a work-related accident on May 23, 2014.

II. 14 WC 32112

Causation

Petitioner argues that in addition to his low back condition of ill-being, the May 19, 2014 accident resulted in injuries to his neck and right shoulder as well as the onset of headaches. Having reviewed the evidence, the Commission agrees with the Arbitrator that Petitioner's right shoulder and headache complaints are not causally related; however, the Commission does find the evidence establishes a causal connection between the work injury and Petitioner's cervical spine condition. While the Arbitrator took issue with the variations in Petitioner's description of the accident, the Commission views the evidence differently and finds there is a sufficient thread of commonality. Moreover, the medical records evidence Petitioner complained of neck pain when he presented to Dr. Dunker on May 20, 2014, and the doctor's diagnoses reflect acute cervical spine trauma. Dr. Dunker's records additionally document Petitioner consistently complained of neck pain throughout the ensuing weeks. Therefore, the Commission finds the May 19, 2014 accident resulted in an injury to Petitioner's cervical spine.

The Commission further finds Petitioner reached maximum medical improvement for his injury as of July 15, 2014. On that date, Dr. Thomas Gleason performed a Section 12 examination and record review at Respondent's request. The doctor's report reflects a thorough examination was conducted, after which Dr. Gleason memorialized that, other than pre-existing left elbow trauma, Petitioner had no positive objective findings on physical examination relative to the spine or the extremities. RX1. Dr. Gleason also noted Petitioner's subjective complaints outweighed the objective findings and observed inconsistencies suggesting magnification or exaggeration. The Commission finds these details compelling. Dr. Gleason opined Petitioner had "no current complaints related to the petitioner's work injury of May 19, 2014, based upon the review of records as well as the examination process, knowledge and experience." RX1 Dr. Gleason concluded Petitioner had reached maximum medical improvement and was capable of performing full-duty work without restrictions. RX1. The Commission adopts Dr. Gleason's credible and persuasive conclusions.

The Commission finds Petitioner's cervical and lumbar spine strains were causally related to the undisputed May 19, 2014 work accident. The Commission further finds Petitioner reached maximum medical improvement for all related conditions as of July 15, 2014, the date of Dr. Gleason's Section 12 exam.

Medical Bills

Petitioner reached maximum medical improvement for his work-related injuries on July 15, 2014. Therefore, the Commission finds the following services were causally related to the May 19, 2014 accident and reasonable and necessary pursuant to Section 8(a):

Provider	Dates of Service
Jacob Dunker, Central Illinois Chiropractic	5.20.14 – 7.14.14
Pekin Hospital	5.20.14
Central Illinois Radiological Assoc.	5.20.14

Tremont Medical Group 5.30.14 – 6.25.14

Respondent shall pay these expenses, subject to Section 8.2, with credit given for any medical benefits that have been paid. The Commission finds the remainder of the expenses in Petitioner's Exhibit 8 are unrelated to the May 19, 2014 accident and are hereby denied.

Permanent Disability

Petitioner's work accident occurred after September 1, 2011; therefore, §8.1b applies. 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) – impairment report

Neither party submitted a §8.1b(a) impairment report. In *Corn Belt Energy Corp. v. Illinois Workers' Comp. Comm'n*, 2016 IL App (3d) 150311WC, ¶47, 56 N.E.3d 1101, the Appellate Court held an impairment report is not a prerequisite to an award of permanent partial disability benefits. As such, the Commission assigns no weight to this factor and will assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1(b)(ii) – occupation of the injured employee

Prior to his accidental injury, Petitioner worked as a laborer for Respondent's tree trimming business, a position he had held for three years. He did not return to his pre-injury job, however, the Commission emphasizes Dr. Gleason concluded Petitioner requires no restrictions and has no physical limitations preventing him from performing such work. The Commission places significant weight on this factor as being indicative of reduced permanent disability.

Section 8.1(b)(iii) – age of the employee at the time of the injury

Petitioner was 47 years old on the date of his accidental injury. Petitioner is well into his anticipated work-life and will therefore face any residual disability for a shorter period. The Commission finds this factor weighs in favor of decreased permanent disability.

Section 8.1(b)(iv) - future earning capacity

Given Dr. Gleason's conclusion that Petitioner is capable of unrestricted work, the Commission finds there is no credible evidence of a negative impact on Petitioner's future earning capacity. The Commission finds this reflects a reduced permanent disability.

Section 8.1(b)(v) – evidence of disability corroborated by treating medical records

Petitioner testified to significant ongoing complaints. He stated his neck hurts a lot and is stiff, his low back feels like "it's on fire," he gets daily headaches, and he has also developed a ringing in his ears. The Commission finds the medical records do not contain objective findings which corroborate Petitioner's proclamations of severe disability. Rather, the medical records document exaggerated pain response, excessive treatment, and doctor shopping.

Petitioner underwent emergency room care followed by approximately two months of chiropractic care. As of July 15, 2014, examination of his cervical and lumbar spine revealed no positive objective findings. The Commission finds these facts evidence a good recovery and weigh heavily in favor of reduced permanent disability.

Based on the above, the Commission finds Petitioner's cervical and lumbar strains resulted in permanent partial disability to the extent of a 5% loss of use of the person as a whole under Section 8(d)2.

The Commission recognizes the Arbitrator's award of a 5% loss of the person did not include the cervical spine condition, and therefore it would be anticipated that a higher permanency award would accompany our decision. However, we believe the original award was excessive and, as detailed above, the Commission finds a 5% loss of use of the person as a whole adequately represents Petitioner's cervical and lumbar disability.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $302.24 per week for a period of 6 2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $272.02 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 5% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses incurred from May 19, 2014 through July 15, 2014, as outlined herein, pursuant to §§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 for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

18IWCC0191

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,700.00. 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: MAR 29 2018

L. Elizabeth Coppoletti

LEC/mck

O: 1/30/18

Charles J. DeVriendt

43

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MERRITT, RONALD
Employee/Petitioner

Case# **14WC032112**

14WC036258

BOBBY MANN D/B/A TOPLESS TREE SERVICES
Employer/Respondent

18IWCC0191

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:

1824 STRONG LAW OFFICES
MICHAEL BRANDOW
3100 N KNOXVILLE AVE
PEORIA, IL 61603

1337 KNELL LAW LLC
CHARLES D KNELL ESQ
504 FAYETTE ST
PEORIA, IL 61603

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RONALD MERRITT,
Employee/Petitioner

v.

BOBBY MANN d/b/a TOPLESS TREE SERVICES,
Employer/Respondent

Case # **14** WC **32112**

Consolidated cases: **14 WC 36258**

18IWCC0191

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **5/11/17**. 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 **Choice of physicians**

FINDINGS

On **5/19/14 and 5/23/14**, Respondent *was* operating under and subject to the provisions of the Act.

On 5/19/14, an employee-employer relationship *did* exist between Petitioner and Respondent.

On 5/19/14, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident on 5/19/14 *was* given to Respondent.

Petitioner's current condition of ill-being as it relates to his low back *is* causally related to the accident on 5/19/14 through 7/15/14.

In the year preceding the injury on 5/19/14, Petitioner earned **$23,574.72**; the average weekly wage was **$453.36**.

On 5/19/14, Petitioner was **47** years of age, *married* with **no** dependent children.

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

Respondent *has or will* pay all appropriate charges for all reasonable and necessary medical services for petitioner's low back from 5/19/14 through 7/15/14.

Respondent shall be given a credit of **$2,331.42** for TTD payments related to the injury on 5/19/14, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$2,331.42**.

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

ORDER

The petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury on 5/23/14 that arose out of and in the course of his employment by respondent on 5/23/14. The petitioner's claim with respect to case 14 WC 36258 is denied.

Respondent shall pay Petitioner temporary total disability benefits of $302.24/week for 6-2/7 weeks, commencing 6/2/14 through 7/15/14, as provided in Section 8(b) of the Act.

The respondent shall pay reasonable and necessary medical services related to petitioner's low back from 5/19/14 through 7/15/14, 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.

Respondent shall pay Petitioner permanent partial disability benefits of $272.07/week for 25 weeks, because the injuries sustained caused the 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

5/30/17
Date

ICArbDec p. 2

JUN 12 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 47 year old laborer, sustained an accidental injury that arose out of and in the course of his employment by respondent on 5/19/14 (14 WC 33112). Petitioner further alleges that he sustained another injury on 5/23/14 that arose out of and in the course of his employment by respondent. Respondent disputes that petitioner sustained a work injury on 5/23/14 (14 WC 36258).

On 5/19/14 after lunch, petitioner was riding in the back of pickup truck with a coworker, Cox. Petitioner testified that the driver of the truck was speeding through the streets and slammed on the brakes at the red light. Petitioner testified that he was flung from the back of the truck bed to the front of the truck bed and hit his head and back on the steel truck bed. He complained of right sided low back, middle back, and neck pain. He reported the injury to his supervisor Travis Hilst. Petitioner testified that Hilst would not let him go to the hospital. Cox was not hurt. Petitioner testified on cross examination that after the accident on 5/19/14 he talked to the owner Bobby Mann, who sent him to Pekin Hospital for treatment. Petitioner did not seek treatment that day.

Petitioner testified that after the incident, they proceeded to the job site and he tried to move some brush. As he was doing this he became dizzy and lightheaded and did not perform any more work that day. He drove himself home, about 30 minutes. That night he was sore from his head to his low back.

On 5/20/14 petitioner presented the emergency room at Pekin Hospital at 7:52 am. Petitioner complained of right flank/low back pain, and headaches. He also reported low back pain extending up the right side to his trapezius area. He reported that he was lightheaded and had dizziness the day before. No neck pain was noted. He gave a history of riding in the back of a dump truck on 5/19/14, and when the brakes were applied he slid forward, striking his flank on the back of the dump truck bed. He reported that he did not strike his head. He denied any loss of consciousness. X-rays of the lumbosacral spine showed no acute abnormality and degenerative changes. He was assessed with a contusion and strain of the back and was given flexeril, was told to taken Tylenol or ibuprofen as needed, and told to return with any worsening symptoms or new concerns. He was also told to follow up with his doctor this week.

That same day, petitioner presented to Central Illinois Chiropractic. He gave a history of sitting in the back of a truck, falling off a log and being slammed against the bed of the truck. He complained of right neck, and right low back, bilateral hip pain, as well as right groin, and left elbow pain. He reported that his condition was worsening. He noted that he was dizzy and lightheaded since the accident. Petitioner underwent chiropractic treatment for his complaints. He was also seen on 5/22/14.

On 5/23/14 petitioner had an altercation with his boss Travis Hilst. He testified that he was told to come get his check at the company lot. He stated that he sat and waited but Hilst did not show up when the crew showed up. He testified that Hilst came up to his car and they had a conversation. He stated that Hilst asked him if he had a case against Bobby, but he said no. Petitioner testified that Hilst then punched him in the face.

On 5/23/14 petitioner returned to the emergency room at Pekin Hospital at 13:34 pm. He reported that he was punched in the face at work. He complained of neck pain and headaches. He also reported problems with vision. An exam revealed tenderness to the nasal bridge with swelling. No septal hematoma was noted. Petitioner reported increased neck stiffness. Petitioner underwent a CT scan of the cervical spine. The impression was no acute cervical spine fracture, and degenerative changes. X-rays of the nasal bones showed mildly depressed nasal bone fractures. CT of the facial bones showed anterior bilateral nasal bone fracture with minimal deformity. Petitioner denied any memory impairment. He was diagnosed with a nasal fracture and neck pain. He was instructed to return, or see his doctor, if his pain worsened or he had any new concerns.

On 5/23/14, after the alleged accident on 5/23/14, petitioner returned to the chiropractor. Petitioner received chiropractic care that day. Between 5/23/14 and 9/9/14 petitioner underwent approximately 45 chiropractic sessions. During this period petitioner received no lasting relief for his symptoms.

On 5/30/14 petitioner presented to Tremont Medical Group for a transition into care from the Pekin Hospital. He was seen by Dr. Kellenberger. Petitioner gave a history of rolling in the back of a dump truck. He reported that he hit the back of his head hard on the metal truck bed. He further reported that he argued with his boss and said he was accused of suing the company, and was punched in the nose by a fellow employee. He complained of headaches, neck pain, mid and lower back pain, and right sided pain going into the groin. He also noted visual changes, dizziness, lightheadedness, and stiffness. He reported that he was out of Hydrocodone. An examination revealed raccoon eyes with a broken nose; back of head no longer swollen; and very tender. Petitioner was assessed with a headache and prescribed Hydrocodone.

On 6/2/14 petitioner returned to Dr. Kellenberger. He reported that the back of his head was still sore, but improving. An examination revealed an improvement in bruising and pain. He was assessed with a headache.

On 6/2/14 petitioner resumed treatment at Central Illinois Chiropractic.

On 6/6/14 petitioner returned to Dr. Kellenberger for recheck of his headache. He reported that his head was starting to improve. Blurriness in his left eye was noticeably better. A mental status exam was performed and was normal. He reported pain in the trapezius muscle on the right. Petitioner was assessed with a headache. He was given scripts for Hydrocodone, and Cyclobenzaprine. He stated that his pain was worse

because he had no Hydrocodone. Petitioner reported a burning sensation in his right shoulder. Dr. Kellenberger thought it was likely the trapezius muscle.

On 6/13/14 petitioner reported to Dr. Kellenberger that his nose was better, but he still had some pain. He stated that the back of his head remained sore, but not at the point of impact. He stated that his neck was now hurting. A mental status exam was normal. Petitioner still had pain in the trapezius muscle on the right. Petitioner's assessment remained the same. Petitioner was told to wean off the hydrocodone.

On 6/25/14 petitioner returned to Dr. Kellenberger. He reported headaches all the time, and ongoing back and neck soreness. Petitioner stated that he was seeing a chiropractor for his back. He clarified that the injuries to his neck and back happened while riding in the back of a truck, and the broken nose was 4 days later when he returned to the job site. Dr. Kellenberger assessed headache, neck pain, back pain and visual complaint. Petitioner claimed his symptoms were getting worse and he had new complaints regarding balance and visual symptoms. He requested more hydrocodone. Dr. Kellenberger recommended a neurology referral/evaluation.

On 7/15/14 petitioner underwent a Section 12 examination performed by Dr. Thomas Gleason, at the request of the respondent. Petitioner gave a history of sitting in the back of a dump truck on 5/19/14 when the driver hit the brakes and he was thrown against the inside of the truck bed hitting the back of his head and spine. He stated that he sustained an injury to his head, right shoulder, neck, thoracic spine and low back with some pain over the anterior pelvic area with radiation into his right testicle at times. He stated that he worked over the next hour, and reported the injury to his boss. He stated that he developed increasing pain, dizziness and blurred vision. He stated that he did not seek treatment at the request of his boss that day, but did seek emergency treatment the next day. He also treated with a chiropractor. Petitioner stated that he takes Hydrocodone and a muscle relaxant. Petitioner stated that he has not worked since 5/20/14. He stated that as a tree laborer he is required to lift over 100 pounds. He denied any problems with his right shoulder, neck, thoracic spine or lower back prior to 5/19/14. He also denied any injuries after 5/19/14.

Following an examination, medical review, and diagnostic studies Dr. Gleason 's diagnosis was no positive objective findings on physical examination relative to the spine and the extremities, other than those related to the left elbow, unrelated to 5/19/14. He was of the opinion that petitioner's subjective complaints outweighed his objective finding and that petitioner's subjective complaints cannot necessarily be confirmed by objective findings. He was of the opinion that there exists certain findings reflecting inconsistencies and contradictions suggesting magnification or exaggeration. Dr. Gleason opined that petitioner is capable of working regular duty without restrictions. He encouraged a home exercise program, and over the counter medications or NSAIDs. Dr. Gleason opined that petitioner had no current complaints related to his work injury

on 5/19/14, based upon review of records, as well as his examination, knowledge and experience. He opined that no further treatment was needed related to the injury on 5/19/14. He opined that petitioner reached maximum medical improvement for any injuries on 5/19/14 within a relatively brief approximately 4 week period of time. Dr. Gleason's prognosis for petitioner was excellent. He opined that petitioner did not need any restrictions.

On 8/5/14 petitioner returned to Dr. Kellenberger. He reported that the injuries sustained in the work accident on 5/29/14 were extending into his right abdomen. He also reported that his headaches were in his jaw and anterior neck. He stated that his head sticks in various positions. He denied any blurriness. He stated that he does get lightheaded and unstable. Dr. Kellenberger's assessment was headache, back pain and neck pain. He referred petitioner to neurology and gave petitioner refills for his medications. He was of the opinion that petitioner's abdominal complaints may be confounded by a gallbladder problem.

On 9/22/14 petitioner returned to Dr. Kellenberger. It was noted that petitioner missed 3 appointments. He stated that he "just haven't gone" to neurologist. Not sure if appointment was ever made. Petitioner asked for a referral to Prairie Pain and Spine. Petitioner continued to complain of neck and back pain. He stated that it was getting better, especially after it popped one day. Dr. Kellenberger's assessment was neck pain and back pain. He referred petitioner to a pain specialist. He restricted petitioner from lifting in excess of 5 pounds. Dr. Kellenberger gave petitioner referral to Prairie Pain and Spine Clinic for an evaluation, at his request.

On 10/21/14 petitioner presented to Prairie Spine and Pain records. Petitioner gave a history of sitting on a log in the back of a dump truck when the driver slammed on the brakes. He reported that his head hit the front of the truck bracket. He reported immediate pain in his neck, thoracic spine and lumbar spine. He complained of confusion, headaches and dizziness since the accident. He also reported shooting pains down both arms. Dr. Kube assessed cervicalgia and referred petitioner to physical therapy in the facility. He restricted petitioner to light activity work with frequent lifting of 10 pounds, and limited lifting up to 35 pounds, rare overhead and floor to waist lift, limited bending and twisting, and limited prolonged sitting or standing. X-rays of the cervical spine were taken that showed arthritis at several levels with osteophytes formation off the anterior vertebral bodies, specifically at C4, C5, and C6.

On 10/22/14 petitioner complained of neck pain, back pain and headaches to Dr. Kellenberger. He stated that he was being seen at Prairie Pain and Spine Clinic and neurology. He also reported that he was heading to physical therapy. Dr. Kellenberger assessed neck pain and back pain. He told petitioner to continue with the pain clinic and neurology.

On 10/24/14 petitioner returned to Prairie Pain and Spine with many complaints. Derek Morrow, Dr. Kube's PA, noted that they were focusing on the cervical spine. In addition to the complaints he identified on 10/21/14 petitioner also reported problems with memory. Morrow examined petitioner and recommended that the neurologist handle petitioner's medications. A cervical MRI was ordered, and physical therapy and trigger joint injections were discussed. Petitioner was continued on light duty.

On 11/1/14 petitioner last treated with the chiropractor. He reported that he was sore, but overall was feeling better than before. He reported right sided headaches and sharp pain going down his right shoulder. It was noted that petitioner was improving.

On 11/3/14 petitioner began a course of physical therapy at Prairie Spine and Pain. Petitioner complained of right, greater than left sided, neck pain, right TMJ and auricular pain, right anterior shoulder pain that radiates toward the lateral aspect of the right elbow, right, greater than left sided, thoracolumbar pain increased with standing, and some dizziness, memory loss and tinnitus. Petitioner gave a history of low back pain following a couple motor vehicle accidents that resulted in low back injuries that were treated successfully with chiropractic care. Petitioner underwent 15 sessions through 12/12/14.

On 12/3/14 petitioner reported to Dr. Kellenberger that his back pain was improved and he was doing better. He reported that his neck pain was unchanged. Dr. Kellenberger assessed neck pain and back pain. He noted that petitioner's neck pain was not improved and he may need a neurosurgery referral, as directed by pain specialist. He noted that petitioner's back pain was improving and he was going to continue in physical therapy.

On 12/22/14 petitioner returned to Morrow. Morrow noted that petitioner was not really progressing in physical therapy. He recommended 2 more weeks of physical therapy to put an emphasis on strengthening techniques. Petitioner's restrictions remained the same. Petitioner underwent an additional 3 therapy sessions through 1/2/15.

On 1/6/15 Dr. Kube drafted a work status report and petitioner's restrictions remained unchanged.

On 1/8/15 Morrow was of the opinion that petitioner was progressing slowly. Petitioner reported that his neck pain and bilateral shoulder pain was 5/10. He stated that he felt a lot better. Morrow was of the opinion that petitioner had pleateaued. He offered petitioner work conditioning or an FCE. Petitioner chose the FCE. This was never done.

On 1/30/15 petitioner reported to Dr. Kellenberger that he was worried about himself getting angry too easily. He reported anger issues. He stated that he was out of cash and was ripped off by daughter, and friend, and nearly trashed his truck. He said he gets really frustrated and was there to discuss his anger. He stated that

he did not want to snap and hurt anyone. There was no mention of neck or back problems at this visit. Dr. Kellenberger prescribed medication. Petitioner also had a visit on 3/19/15. He made no complaints of any neck or back problems.

On 2/9/15 petitioner presented to Haynes Family Chiropractic for complaints of back pain and neck pain from injuries sustained while working for respondent. Petitioner gave a history of sitting in a truck bed on a log with his back to the corner of the truck bed directly behind the driver's side of the cab. When the driver slammed on the brakes he fell backwards off the log and stuck the lower right side of his head on a steel portion of the truck bed. He noticed immediate pain in his head and lower right side of his spine, and dizziness. He claimed that he was diagnosed with a concussion and whiplash at the hospital on 5/20/14. He also reported that he had pain radiating into the entirety of the right arm, radiating pain into the right side of the face, ringing in the right ear, memory loss, right shoulder pain, and irritability. Petitioner also reported that three days after the truck accident he was struck in the nose by a co-worker's fist in the company parking lot. He stated that he was seated in his truck with his head turned to the left when he was struck. Petitioner began another course of chiropractic treatment. Petitioner underwent an additional 22 sessions through 5/25/15.

On 5/25/15 Dr. Haynes informed petitioner that he would no longer be a patient at the office. Dr. Haynes gave petitioner a letter stating that he would no longer be a patient and provided him with 4 other options for chiropractic care in a closer proximity to his home.

On 7/7/16 the evidence deposition of Dr. Dunker was taken on behalf of the petitioner. On 5/20/14 petitioner presented to Dr. Jacob Dunker for chiropractic treatment. Petitioner's chief complaint was posterior head, posterior neck, right side of neck, left trapezius, upper thoracic, right posterior trapezius, mid thoracic, left lumbar and lumbar dull and aching discomfort. Dr. Dunker treated petitioner's lumbar and cervical spine.

He testified that on 5/20/14 he diagnosed acute subluxation complex at T2-T3, and acute subluxation complex at L4-L5, and exacerbation of the chronic subluxation complex at T5-T10. He related these findings to the incident the day before. Dr. Dunker noted that on 5/21/14 petitioner was doing a lot better and his vision was better, but he was still having a little back, neck and head pain. Dr. Dunker stated that he saw petitioner 2 times on 5/23/14. At the first visit petitioner was doing a lot better. He still had some soreness in the low back and neck, but was 50% improved. At the 2nd visit that day, petitioner told Dr. Dunker that he had been punched in the face and broke his nose. He complained of neck pain after being punched in the nose. After this petitioner reported bilateral suboccipital pain in his neck, along with his mid trapezius area for two hours. He stated nothing was helping his pain. Dr. Dunker noted that on this visit petitioner's active range of motion had decreased in his cervical spine with pain in all directions. After this date petitioner had bad headaches bi-

temporally, blurry vision, and pain shooting down to his right shoulder. On 5/28/14 petitioner told Dr. Dunker that his vision was a little better, and he was still having headaches with pressure in his head, and was experiencing bilateral low back pain. On 5/30/15 petitioner told Dr. Dunker he had short term relief of his low back pain, with some burning sensation, but his neck was getting worse. Dr. Dunker noted that on 6/2/14 petitioner was feeling alright. He no longer had any burning pain, and had less pressure in his head. Dr. Dunker testified that he continued to treat petitioner through 6/11/14, and petitioner remained roughly the same with some slight improvement. From 6/13/14 through 6/23/14 Dr. Dunker testified that petitioner was progressing at the beginning. He testified that on 6/20/14 petitioner told him that he soaked in his bathtub and noticed extreme low back pain after getting out. On 7/7/14 and 7/18/14 Dr. Dunker noted that petitioner had an exacerbation of his low back pain, and was improving with respect to his neck pain. Dr. Dunker testified that petitioner's progress throughout his treatment was like a roller coaster, up and down. Dr. Dunker noted that when saw petitioner on 9/9/14 his major complaint was right-sided headache. When he saw petitioner on 11/1/14 he noted that petitioner was sore, but overall was feeling better than before. His right-sided headaches were sharp and going down to his right shoulder. Dr. Dunker last saw petitioner on 5/20/16. At that time petitioner's complaints were in the posterior of his head, right side of his neck, left trapezius, upper thoracic, right posterior trapezius, mid thoracic, left lumbar and lumbar area. He stated these complaints were the same as petitioner had in 2014.

Dr. Dunker opined that as of 5/20/16 his diagnosis of petitioner was chronic subluxation complex of his cervical area and lumbar spine. He further opined that petitioner's cervical and lumbar conditions, and headaches could be related to the incidents on 5/19/14 and 5/23/14. He opined that the treatment he provided petitioner was reasonable and necessary. Dr. Dunker was of the opinion that petitioner had reached maximum medical improvement. Dr. Dunker testified that he was paid through 7/25/14.

On cross examination Dr. Dunker opined that petitioner's complaints were primarily right-sided and were to the cervical and lumbar area, and headaches. Dr. Dunker testified that he never took any x-rays of the lumbar spine. He took cervical x-rays after each alleged incident on 5/19/14 and 5/23/14 and thoracic x-ray after the visit on 5/19/14. Dr. Dunker testified that he treated petitioner with ultrasound, hot packs and manipulations. He testified that he did not feel any of petitioner's complaints revealed any type of radiculopathy or disc problem in the thoracic, lumbar or cervical region. Dr. Dunker never took petitioner off work or placed restrictions on him. Dr. Dunker opined that petitioner's symptoms would wax and wean. Dr. Dunker had no opinion on petitioner's vision issues. He testified that it was an occasional issue and could not say it was related to the incidents. Dr. Dunker opined that petitioner's condition on 5/20/14 and 11/1/14 were the same.

Petitioner testified that he is not working and has not worked since 5/20/14, but is looking for work. He testified that his neck still hurts a lot and has gotten worse since the accidents. Petitioner denied any injuries to his neck before 5/19/14, but did admit to prior low back problems that had resolved by the 5/19/14. Petitioner testified that his low back burns a lot, hurts with activities, and the pain is sharp. Petitioner testified that he takes pills and muscle relaxers. He stated that he gets headaches everyday for no reason. He also testified that his ringing in his ears has continued every day and is sometimes louder. Petitioner testified that he can do activities around the house, but is sore afterward.

Petitioner was paid temporary total disability benefits from 6/2/14 through 7/22/14. Respondent terminated benefits on this day, based on the findings of Dr. Gleason.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

The parties have stipulated that the petitioner sustained an accidental injury that arose out of and in the course of his employment by respondent on 5/19/14. The petitioner also claims he sustained an accidental injury that arose out of and in the course of his employment by respondent on 5/23/14. The respondent claims the petitioner did not sustain an accidental injury that arose out of and in the course of his employment by respondent on 5/23/14.

The alleged injury on 5/23/14 involves an altercation between petitioner and his boss Hilst, wherein Hilst punched petitioner in the face and fractured his nose. An altercation resulting from a quarrel having its origin in work, such as some disagreement as to how the work is to be done and the manner of doing it, is held compensable. In cases involving an issue of who is the initial aggressor, the appellate court has ruled that in an altercation between employees, there can only be one initial aggressor.

Petitioner alleges that after the work injury on 5/19/14 he did not return to work for respondent, and on 5/23/14 was told to come to the company lot to collect his check. Petitioner testified that he sat and waited for Hilst to come, but Hilst did not show up when the crew showed up. Petitioner testified that some time after the crew arrived Hilst came up to his car and they had a conversation. Petitioner was light on the details of that conversation, but stated that Hilst asked him if he had case against Bobby, and he said no. Petitioner testified that Hilst then punched him in the face. Petitioner provided no further testimony regarding this incident.

Based solely on the petitioner's testimony, given the fact that Hilst was not called as a witness by either party, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that the quarrel he had with Hilst had its origin in the work he was performing for respondent. Although one could reasonable infer that "Bobby" was Bobby Mann, the owner of the company, petitioner failed to provide any

credible evidence regarding what the alleged lawsuit was about. Additionally, the arbitrator finds the petitioner failed to offer any credible evidence that he was working for respondent on 5/23/14, given the fact that he was allegedly meeting Hilst to pick up his check for his work through 5/19/14. Petitioner, himself, testified that he did not work for respondent after 5/19/14.

Having failed to offer into evidence detailed information about the alleged lawsuit, or provide credible evidence that he was even working for respondent on 5/23/14, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his face that arose out of and in the course of his employment by respondent on 5/23/14.

The arbitrator finds the petitioner sustained an accidental injury that arose out of and in the course of his employment by respondent on 5/19/14 (14 WC 32112), but has failed to prove by a preponderance that he sustained an accidental injury that arose out and in the course of his employment by respondent on 5/23/14 (14 WC 36258).

E. WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT?

The issue of timely notice is in dispute only with respect to the alleged injury on 5/23/14 (14 WC 36258). Having found the petitioner has failed to prove by a preponderance that he sustained an accidental injury that arose out and in the course of his employment by respondent on 5/23/14, the arbitrator finds this issue moot.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Having found the petitioner has failed to prove by a preponderance that he sustained an accidental injury that arose out and in the course of his employment by respondent on 5/23/14 (14 WC 36258), the arbitrator will only address the issue of causal connection as it relates to the accident petitioner sustained on 5/19/14 (14 WC 23112).

It is unrebutted that petitioner sustained an accidental injury that arose out of and in the course of his employment by respondent on 5/19/14, when the truck he was riding in slammed on the brakes at a stop light. However, the mechanism of injury and actual injuries sustained is inconsistent throughout the record. Petitioner gave 8 different accident histories and different histories as to the injuries he allegedly sustained.

1. On 5/20/14 petitioner gave his first history of accident on 5/19/14 at the emergency room. He gave a history of riding in the back of a dump truck on 5/19/14, and when the brakes were applied he slid forward, striking his flank on the back of the dump truck bed. He specifically stated that he did not strike his head. He reported low back pain up the right to his trapezius area. He provided no history of any neck pain. He also specifically stated that he did not strike his head. He reported that he was lightheaded and dizzy the day before, but petitioner did not complain of any

lightheadedness or dizziness the emergency room. He was assessed with a concussion and back strain. X-rays were only taken of his low back.

2. Later on 5/20/14 he sees Dr. Dunker, a chiropractor. He gave a history of sitting in the back of a truck, falling off a log and being slammed against the bed of the truck. He complained of right neck, right low back, bilateral hip pain, right groin pain, and left elbow pain. He reported that his condition was worsening. He reported that he was dizzy and lightheaded since the accident.
3. On 5/23/14 petitioner again presented to emergency room after he was struck in the face by Hilst. He complained of neck pain and headaches. He also reported vision problems and increased neck stiffness. This was the first time petitioner underwent a CT scan of the cervical spine. Petitioner was diagnosed with a nasal fracture and neck pain.
4. On 5/30/14 petitioner presented to Dr. Kellenberger. He gave a history of rolling in the back of a dump truck and hitting his head hard on the metal truck bed. He complained of headaches, neck pain, mid and low back pain, right sided pain going in the groin, visual changes, dizziness, lightheadedness, and stiffness.
5. On 7/15/14 petitioner told Dr. Gleason that he was sitting in the back of the dump truck on 5/19/14 when the drivers hit the brakes and he was thrown against the inside of the truck bed hitting the back of his head and spine. He reported an injury to his head, right shoulder, neck, thoracic spine and low back with some pain over the anterior pelvic area with radiation into his right testicles at times.
6. On 10/21/14 petitioner presented to Dr. Kube and gave a history of sitting on a log in the back of a dump truck when the driver slammed on the brakes. He reported that his head hit the front of the truck bracket. He reported immediate pain in his neck, thoracic spine and low back. He complained of confusion, headaches and dizziness since the accident, and shooting pain down both arms.
7. On 2/9/15 petitioner presented to Haines Family Chiropractic. He gave a history of sitting in a truck bed on a log with his back to the corner of the truck bed directly behind the driver's side of the cab. When the driver slammed on the brakes he fell backwards off the log and struck the lower right side of his head on a steel portion of the truck bed. He stated that he noticed immediate pain in his head and lower right side of his spine, and dizziness. He also reported that he had pain radiating into the entirety of the right arm, radiating pain into the right side of the face, ringing in the right ear, memory loss, right shoulder pain, and irritability.
8. At trial, petitioner gave a history of riding in the back of a pickup truck with a co-worker when the driver of the truck was speeding through the streets and slammed on the brakes at the red light. He testified that he flung from the back of the truck bed to the front of the truck bed and hit his head and back on the steel truck bed. He testified that he had immediate right sided low back, middle back, and neck pain.

Based on these multitude of accident histories, the only thing the arbitrator finds consistent throughout is that petitioner was in the back of a truck when the driver slammed on the brakes. Petitioner provided differing histories as to where he was located in the truck when the driver slammed on the brakes, with some differing histories being to different healthcare providers on the same day. In some histories he indicated that he was at the back of the truck. In others he was just behind the driver. In others it is not clear. In some histories he slid

forward. In others he was flung forward, in another he was rolling around the truck bed, and in another he just fell off a log and struck himself.

In addition to the discrepancies in the alleged mechanism of injury, the arbitrator also finds significant discrepancies in the alleged injuries associated with the injury on 5/19/14. The history and complaints most contemporaneous to the injury were those that he reported to the emergency room on 5/20/14. Petitioner stated that he slid forward when the brakes were applied and struck his flank on the back of the dump truck bed. He had complaints of low back pain extending up on the right to the trapezius area. He did report headaches. The arbitrator finds it significant that petitioner did not give any history of striking his head or neck and had no neck complaints. He also denied any loss of consciousness and only reported lightheadedness and dizziness the day before. He reported no complaints of any lightheadedness or dizziness at the hospital. Petitioner was worked up for his low back/flank pain and assessed with a contusion and strain of the back.

It was after this visit that the mechanism of injury became more traumatic and his injuries far more extensive. In fact, when petitioner also presented to Dr. Dunker on 5/20/17 his accident history changed from "slid forward " stuck his flank on the bed of the dump truck, to falling off a log and being "slammed" against the bed of the truck. Additionally, his minor complaints of low back pain extending on the right to the trapezius area changed to complaints of right neck and low back pain, bilateral hip pain, right groin pain and left elbow pain. Petitioner then also reported dizziness and lightheadedness which he did not report a few hours earlier.

Based on these inconsistent histories and alleged injuries, the arbitrator finds the accident history and injuries reported at the emergency room on the morning of 5/20/14 were the most contemporaneous to the accident and therefore the most credible. The arbitrator finds the remaining 7 histories/alleged injuries not as persuasive.

Although petitioner treated with a number of providers for his alleged injuries, only Dr. Gleason and Dr. Dunker provided causal connection opinions. Dr. Gleason examined petitioner on 7/15/14 at the request of the respondent. Dr. Gleason found no positive objective findings on physical examination relative to the spine and the extremities, other than those related to the left elbow, which he opined was not related to the accident on 5/19/14. He was of the opinion that petitioner's subjective complaints outweighed his objective findings and his subjective complaints could not necessarily be confirmed by objective findings. He was also of the opinion that there were certain findings that reflected inconsistencies and contradictions suggesting magnification or exaggeration. Dr. Gleason opined that petitioner had no current complaints related to his work injury on 5/19/14. He was of the opinion that petitioner reached maximum medical improvement for any injuries sustained on 5/19/14 within a 4 week period of time.

Dr. Dunker provided chiropractic care to petitioner from 5/20/14 through 5/20/16. Dr. Dunker noted that when he saw petitioner on 5/23/14 before the alleged accident that day where he was punched in the face, petitioner reported that he was doing a lot better. He reported some soreness in his low back and neck, but was 50% improved. When petitioner returned later that day after being punched in the face, he had significantly increased pain in his neck, and his active range of motion was decreased in his neck in all directions. After this date petitioner had bad headaches bi-temporally, blurry vision, and pain shooting into his right shoulder. The arbitrator finds it significant that petitioner did not have any of these complaints at the emergency room on 5/20/14.

Dr. Dunker opined that petitioner's cervical and lumbar conditions, and headaches "could be" related to the incidents on 5/19/14 and 5/23/14. He was of the opinion that petitioner had reached maximum medical improvement, but did not indicate on what date. Dr. Dunker was also of the opinion that petitioner's complaints did not reveal any type of radiculopathy or disc problem in the lumbar, thoracic, or cervical region. Dr. Dunker had no opinion with respect to petitioner's vision issues, and could not say it was related to the incidents.

Based on the above, as well as the credible evidence the arbitrator finds the opinions of Dr. Gleason more credible and consistent with the credible medical records of the emergency room on 5/20/14. The arbitrator finds the petitioner sustained a strain and contusion his lumbar spine and reached maximum medical improvement for these injuries by 7/15/14, the date he was examined by Dr. Gleason. The arbitrator finds all of petitioner's other complaints not causally related to the injury he sustained on 5/19/14.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found the petitioner has failed to prove by a preponderance that he sustained an accidental injury that arose out and in the course of his employment by respondent on 5/23/14 (14 WC 36258), the arbitrator will only address the issue of medical services as it relates to the accident petitioner sustained on 5/19/14 (14 WC 23112).

Having found the petitioner's current condition of ill-being as it relates to his low back was causally related to the injury he sustained on 5/19/14 through 7/15/14, the date he was examined by Dr. Gleason, the arbitrator finds all treatment petitioner received for his low back from 5/19/14 through 7/15/14 was reasonable or necessary to cure or relieve petitioner from the effects of the injury he sustained on 5/19/14.

The respondent shall pay reasonable and necessary medical services related to petitioner's low back from 5/19/14 through 7/15/14, as provided in Section 8(a) and Section 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.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner made no claim for temporary total disability benefits with respect to case 14 WC 36258.

Petitioner alleges that with respect to the injury on 5/19/14 he was temporarily total disabled from 6/2/14 through 2/8/15. Respondent claims that petitioner was temporarily totally disabled from 6/2/14 through 7/15/14.

Having found petitioner's current condition of ill-being as it relates to his low back was causally related to the injury he sustained on 5/19/14 through 7/15/14, the date he was examined by Dr. Gleason, the arbitrator finds the petitioner is entitled to temporary total disability benefits only through 7/15/14.

Based on the above, as well as the credible evidence the arbitrator finds respondent shall pay petitioner temporary total disability benefits of $302.24/week for 6-2/7 weeks, commencing 6/2/14 through 7/15/14, as provided in Section 8(b) of the Act.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found the petitioner has failed to prove by a preponderance that he sustained an accidental injury that arose out and in the course of his employment by respondent on 5/23/14 (14 WC 36258), the arbitrator will only address the issue of nature and extent of the injury as it relates to the accident petitioner sustained on 5/19/14 (14 WC 23112).

As a result of the accident on 5/19/14 the arbitrator finds the petitioner sustained a contusion and low back strain for which he reached maximum medical improvement by 7/15/14.

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 laborer with a tree cutting service at the time of the accident and that according to Dr. Gleason on 7/15/14 was able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that 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 47 years old at the time of the accident and capable of many more years of employment. Because of this, the Arbitrator therefore 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 has shown no evidence that he was not able to return to his regular duty job on 7/15/14 as a result of his injury on 5/19/14. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that on 5/20/14 petitioner presented to the emergency room and reported that he slid forward when the brakes were applied and struck his flank on the back of the dump truck bed. He had complaints of low back pain extending up on the right to the trapezius area. He did report headaches. The arbitrator notes that petitioner did not give any history of striking his head or neck, and reported no neck complaints. He also denied any loss of consciousness and only reported lightheadedness and dizziness the day before. He reported no complaints of any lightheadedness or dizziness at the hospital. Petitioner was worked up for his low back/flank pain and assessed with a contusion and strain of the back. Later that day he presented to Central Illinois Chiropractic with additional complaints not mentioned a few hours earlier at the emergency room. Then, on 5/23/14 petitioner reported that he was doing a lot better. He still had some soreness in the low back and neck, but was 50% improved. When Dr. Gleason examined petitioner he found no positive objective findings on physical examination relative to the spine and the extremities, other than those related to the left elbow, which he opined was not related to the accident on 5/19/14. He was of the opinion that petitioner's subjective complaints outweighed his objective findings and his subjective complaints could not necessarily be confirmed by objective findings. He was of the opinion that there were certain findings that reflected inconsistencies and contradictions suggesting magnification or exaggeration. 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 5% loss of use of his person as a whole pursuant to §8(d)2 of the Act.

O. CHOICE OF PHYSICIANS?

Having found the petitioner has failed to prove by a preponderance that he sustained an accidental injury that arose out and in the course of his employment by respondent on 5/23/14 (14 WC 36258), the arbitrator will only address the issue of choice of physicians as it relates to the accident petitioner sustained on 5/19/14 (14 WC 23112).

As a result of the injury on 5/19/14 petitioner presented to the emergency room, and then began treating at Central Illinois Chiropractic for his injuries. After that petitioner presented to Dr. Kellenberger at Tremont Hospital. Lastly, petitioner presented for treatment at Prairie Pain and Spine Clinic. Pursuant to Section 8(a) of the Act the employer's liability to pay for such medical expenses selected by the petitioner shall be limited to all (1) all first aid and emergency treatment; plus (2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical services in the chain of referrals from said initial service provider; plus (3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said initial service provider.

Given that petitioner selected Central Illinois Chiropractor as his initial choice, and Tremont Medical Group as his subsequent choice, the arbitrator finds all reasonable and necessary medical services provided by these providers for petitioner's low back from 5/19/14 through 7/15/14 are within the chain of referral. The arbitrator finds all other treatment for petitioner's low back is outside of the chain of referrals and respondent is not reasonable for payment of these medical expenses.

Given that between the period of 5/19/14 and 7/15/14 the petitioner only treated with Central Illinois Chiropractor and Dr. Kellenberger at Tremont Medical Group for his injury on 5/19/14, the arbitrator finds all treatment provided for petitioner's low back with these providers is in the chain of referrals.

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

Leanard Payne,
Petitioner,

vs.

NO: 10WC 16857

18IWCC0192

Dunnett Bay Construction,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical, 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 November 1, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,100.00. 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: MAR 29 2018
o032018
MJB/jrc
052

/s/ Michael J. Brennan
Michael J. Brennan

Kevin W. Lamborn

18IWCC0192

DISSENT

I believe the evidence shows that Petitioner, at the very least, suffered a lumbar strain as a result of the undisputed accident on 4/21/10, and that his current condition of ill-being relative to his lower back is causally related to said accident per the opinion of treating orthopedic surgeon Dr. Rubinstein. Indeed, even Dr. Salehi, one of Respondent's §12 examining physicians, was willing to concede that Mr. Payne suffered either a lumbar strain or a temporary exacerbation of his pre-existing lumbar condition as a consequence of the incident.

Furthermore, while the history of accident provided by Petitioner admittedly varies slightly between the various medical providers/examiners, particularly with respect to whether he was thrown backwards and/or fell to the ground as a result of the incident, the histories as a whole consistently reflect a viable and forceful mechanism of injury involving a ruptured high-pressure hose containing hot oil resulting in credible complaints of pain in his left knee, left ankle and eventually his lower back. In fact, the pain diagram completed at the time of Petitioner's first visit with Dr. Virkus on 4/28/10 described lower back pain on the left side made worse by the incident. In addition, Dr. Rubinstein opined that Petitioner's low back symptoms may have been initially overlooked due to the severity of his more-pressing left leg complaints.

More importantly, despite his pre-existing history of low back treatment, Petitioner continued to work full duty as a heavy equipment operator for Respondent up to the date of the accident, and only received a recommendation for lumbar surgery following the incident in question.

As a result, I believe that Petitioner proved by a preponderance of the credible evidence that his current condition of ill-being relative to his lumbar spine is causally related to the accident on 4/21/10, and that as such he is entitled to appropriate compensation under the Act.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PAYNE, LEANARD
Employee/Petitioner

Case# **10WC016857**

DUNNET BAY CONSTRUCTION
Employer/Respondent

18IWCC0192

On 11/1/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
DEBORAH WEISS FERTEL
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
MARK WILKENING
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

Leanard Payne
Employee/Petitioner

Case # **10** WC **16857**

v.

Dunnett Bay Construction
Employer/Respondent

18IWCC0192

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Waukegan**, on **August 25, 2016** and the city of **Rockford**, on **September 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 **April 21, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**84,033.56**; the average weekly wage was $**1,1616.03**.

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 $**28,011.10** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**28,011.10**.

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

ORDER

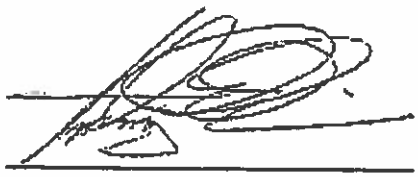
Respondent shall pay Petitioner temporary total disability benefits of $**1,077.35**/week for **18-6/7** weeks, commencing **April 22, 2010** through **August 31, 2010**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**28,011.10** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $**664.72**/week for **19.143** weeks, because the injuries sustained caused the **5%** loss of the Petitioner's **left leg**, and **5%** loss of use of Petitioner's **left foot**, 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.



Arbitrator Anthony C. Erbacci

October 25, 2016
Date

NOV 1 - 2016

FACTS:

On April 21, 2010, the petitioner sustained an undisputed accident which arose out of and in the course of his employment with the respondent. The petitioner was employed by the respondent as a heavy equipment operator and he had been so employed periodically with the respondent for the six years prior to his accident date. The petitioner was injured on April 21, 2010 when a high pressure hose burst, causing the petitioner to be splashed with oil all over his body and to be struck on the the left lower extremity by the hose. The petitioner testified that the pressure of the hose bursting caused injuries to his left foot, his back, his left knee, his left eye, his head, and his ears. The petitioner testified that he did report the incident to his supervisor but did remain at work for the rest of the day. The petitioner returned to work the following day and advised his boss that he was in pain. The petitioner then sought treatment with Centegra Occupational Medicine.

The records of Centegra demonstrate that the petitioner completed an intake form indicating that he had been struck on the left knee and that he had 10/10 pain form his foot to his knee. The petitioner was noted to have complaints of significant left knee pain and left ankle pain as well as ankle deformity. The petitioner indicated that he felt like the plate and/or screws from a previous surgical repair had shifted in his ankle. X-rays of the left knee and ankle were all normal and there was no disruption of the screws or plates noted by the radiologist. The petitioner was assessed with a left knee strain and left ankle sprain and the petitioner advised the physicians that he would continue to use Vicodin which he was already taking for an unrelated concern.

The Arbitrator notes that the petitioner was under medical care for left-sided low back and lower extremity pain prior to the work-related injury. The petitioner treated with Dr. Renata Variakojis in December of 2008 wherein he gave a history of developing left buttock pain suddenly while working with a sledge hammer approximately one month previous. He rated his pain score as seven out of ten. He indicated that the pain was characterized as sharp, shooting, aching, throbbing, stabbing, cramping, and pulling. He described having taken a course of physical therapy without relief and that he was being treated with Oxycontin 40 mg. twice a day. He was only able to sleep from three to seven hours per night.

An MRI of the petitioner's lumbar spine was performed on December 18, 2008, and was reported to reveal an L5-S1 Grade I retrolisthesis, disc bulging, degenerative facet hypertrophy, and marked neuroforaminal stenosis, left greater than right. In addition, a disc bulge at L4-5, and degenerative facet hypertrophy, with moderate foraminal stenosis was noted. At that time, the Petitioner was assessed with low back pain, left lumbar radiculopathy, lumbar degenerative disc disease, lumbar degenerative joint disease, and lumbar spinal stenosis. A lumbar epidural steroid injection and physical therapy were prescribed. Oxycontin was continued. The injections were performed on January 5, 2009 and March 2, 2009.

The records of Dr. Chibber, who the petitioner identified as his family doctor, demonstrate that prior to the April 21, 2010 work accident; the petitioner was treating with him for various medical conditions, including back pain, as well as a lumbosacral strain. The records of Dr. Chibber reveal that the petitioner consistently complained of low back pain to Dr. Chibber throughout 2009. As of December 9, 2009, the petitioner was prescribed Vicodin, extra strength, as well as a Medrol Dose Pac, as directed. Similar treatment and complaints of back pain continued in January, February and

March of 2010. On March 31, 2010, the petitioner was again assessed with a lumbosacral strain and back pain. He was complaining of tenderness in his back. Vicodin was continued.

The records of Dr. Chibber demonstrate that the petitioner saw him on April 22, 2010, reported an injury at his job, and complained of left knee and ankle pain. Thereafter, on May 27, 2010, the doctor added an addendum to the records wherein he added back pain to the petitioner's complaints.

On April 28, 2010, the petitioner sought treatment with Dr. Walter Virkus of Midwest Orthopaedics at Rush. The petitioner gave a history of the work accident of April 21, 2010, reciting that a high pressure device that was full of oil exploded and sprayed him with oil everywhere. He stated that the impact moved him several feet into the machine, but he did not fall down or fall backwards. He advised Dr. Virkus that he continued to work for the rest of the afternoon and then went home. The petitioner complained of left knee, shin, ankle, and foot pain. The doctor reviewed the prior x-rays that had been taken of the left lower extremity and found them to all be within normal limits. The doctor concluded that the petitioner had suffered a minor sprain of his left ankle and knee. Dr. Virkus prescribed physical therapy for the left knee and ankle.

On May 6, 2010, the petitioner returned to Dr. Chibber. The records again reveal complaints of pain involving his left knee and left ankle, with no reference to back pain. However, once again, the doctor amended his records on May 27, 2010, now reflecting back pain as an additional complaint. Thereafter, the petitioner continued treating with Dr. Chibber through December 30, 2010 for various conditions, including low back pain.

The petitioner returned to Dr. Virkus on May 12, 2010, and Dr. Virkus noted that the petitioner walked with a very slow gate. Dr. Virkus concluded that this seemed a bit contrived. Dr. Virkus also noted that the petitioner guarded his movements quite a bit and that this also seemed a little contrived. Dr. Virkus indicated that the petitioner suffered a left knee and ankle sprain and that his complaints outweighed the physical examination. Dr. Virkus referred the petitioner to Dr. Frank Phillips. Physical therapy was continued.

When the petitioner returned to Dr. Virkus on June 9, 2010, he indicated that his left knee had improved, but that his left ankle was much worse. He indicated that therapy had made it worse. Dr. Virkus reviewed the MRI of the ankle and noted no structural damage. Dr. Virkus indicated that it seemed unusual that the petitioner had difficulty with weight bearing and that his pain had worsened. Dr. Virkus treated the petitioner for tendonitis of the foot and ankle and put him in a CAM boot. The petitioner was advised to weight bear as tolerated and physical therapy was placed on hold.

The petitioner returned to Dr. Virkus on July 14, 2010. Dr. Virkus concluded that he had no idea what was going on with the petitioner. He indicated that despite attempts at rest, anti-inflammatory medication, and a completely normal MRI and x-ray, the petitioner continued to deteriorate. Dr. Virkus had no objective findings to correlate with the petitioner's subjective complaints. He indicated there were no radiographic studies that correlated with the petitioner's complaints either. Dr. Virkus released the petitioner to a functional capacity evaluation and determined that it was likely he was at maximum medical improvement.

On July 21, 2010, Dr. Virkus indicated that he reviewed an independent medical evaluation that had been performed by Dr. Steven Kodros. Dr. Virkus indicated that his findings were similar to those of Dr. Kodros. He referenced that Dr. Kodros did not see anything on physical examination or imaging to explain the petitioner's severe ankle symptoms. Dr. Virkus recommended that the petitioner discontinue his use of the boot and he placed him in physical therapy three times a week for four weeks. Following the completion of the physical therapy, it was his recommendation that the petitioner undergo a functional capacity evaluation. Dr. Virkus released the petitioner to light duty with no carrying greater than ten pounds, no ladders and no scaffolds. He indicated that he would see the petitioner again at the conclusion of the functional capacity evaluation.

On July 14, 2010, the petitioner was evaluated by Dr. Steven Kodros at the request of the respondent. Dr. Kodros performed a physical examination of the petitioner and also reviewed the MRI of the left ankle that had been performed on May 3, 2010. Dr. Kodros concluded that there was no evidence of an acute fracture or bony injury. X-rays that were performed subsequent to the accident were also reviewed by Dr. Kodros. No acute abnormalities were noted. Dr. Kodros concluded that the petitioner was status post left ankle sprain. Dr. Kodros offered the opinion that the relative severity of the petitioner's current subjective complaints was not readily supported by objective findings. He concluded that there was no reason to recommend ongoing use of the CAM walker or the cane with respect to the left ankle. He recommended an ongoing functional rehabilitation-type exercise program in conjunction with another course of formal physical therapy. He did not believe that surgery was indicated and did opined that the petitioner was capable of functioning at ground level work at this time, with respect to his left foot and ankle. He did not believe that the petitioner was at maximum medical improvement as of that date.

On June 3, 2010, the petitioner was evaluated by Dr. Frank Phillips on referral from Dr. Virkus. The petitioner advised Dr. Phillips that he had been previously diagnosed with a herniated disc many years ago. He stated that he had been functional and not seeing anyone for medical treatment for his back for many years. He indicated that he was taking only an occasional Vicodin. Dr. Phillips concluded that the petitioner likely suffered from a lumbar sprain/strain type of injury and he recommended a conservative course of treatment with continued physical therapy and an anti-inflammatory, Mobic. He suggested seeing how the petitioner responded to such treatment over the next four weeks. He did not believe the petitioner was capable of working as of that date.

On July 15, 2010, Dr. Phillips prescribed a lumbar MRI. Dr. Phillips also indicated within his records, as of that date, that he had not had an opportunity to review the petitioner's prior medical records which pre-dated the work accident. He did describe that the petitioner told him that he had been having back pain since the time of the work injury.

On September 13, 2010, the petitioner began treating with Dr. Scott Rubinstein. Dr. Rubinstein evaluated the petitioner's left knee, as well as his low back. Dr. Rubinstein injected the petitioner's left knee with Celestone and Lidocaine. His presumed diagnosis relative to the knee was a bone contusion, a collateral ligament sprain, and a possible meniscal tear or synovitis. As far as the petitioner's left foot and ankle were concerned, he prescribed Gabapentin and suggested the petitioner continue to use the CAM walker as needed. As far as the petitioner's low back, he noted tenderness over the lumbar spine. He noted negative straight leg raising and no evidence of significant radicular symptoms. He suggested that it was more of a lumbar muscular sprain than

anything else. He acknowledged that the initial documentation in the records did not have anything written about the petitioner's low back. He stated, however, that he did seek attention for the back in the near term, less than six weeks following the injury from Dr. Frank Phillips, and that it was certainly not incomprehensible that he did not initially report low back pain due to the injury to the leg and knee. There was no suggestion that Dr. Rubinstein reviewed the medical records regarding treatment to petitioner's low back prior to the work injury.

On September 20, 2010, the petitioner underwent an MRI at Advanced Medical Imaging Center. The MRI revealed multilevel degenerative disc disease, with facet arthropathy and minimal Grade I retrolisthesis of L5-S1, with associated central spinal stenosis and neuroforaminal narrowing. The petitioner returned to Dr. Rubinstein on October 13, 2010. Dr. Rubinstein prescribed epidural steroid injections for the back and depending upon his response, suggested that a good physical therapy program thereafter would be appropriate.

On October 28, 2010, the petitioner underwent an independent medical evaluation with Dr. Sean Salehi. Dr. Salehi had the opportunity to review the medical records relative to treatment received by the petitioner prior to his work injury of April 21, 2010. Following his evaluation of the petitioner, and his review of the records, Dr. Salehi concluded that the petitioner sustained a lumbar strain, or at most a temporary exacerbation of a pre-existing condition, reaching MMI within three months from the date of injury. In support of his opinions, Dr. Salehi noted that the petitioner reported that that the previous injury in 2008 had resulted in back pain and no leg pain; while the MRI report of December 18, 2008 references complaints of low back pain and sciatica; that the petitioner's prescription history indicates significant narcotic use and muscle relaxants and a refill of narcotics only three weeks prior to the reported accident, with a prior prescription refill of 100 tablets of Vicodin 40 days earlier, which would suggest that the petitioner was consuming two and one-half tablets per day; that none of the medical notes from April or May mentioned any back pain but were amended on May 27 to include such a diagnosis; and that review of the petitioner's two MRIs from 2008 and 2010 reveal no significant change in the degree of foraminal stenosis and disc disease. Dr. Salehi noted that the foraminal stenosis was significant in both sets of imaging and he concluded that regardless of the cause of the petitioner's low back condition, his subjective symptoms were not explainable on the basis of mechanical back pain as a result of the disc degeneration from L4 to S1.

The petitioner continued treating with Dr. Rubinstein throughout 2010 and 2011. An MRI of the left knee was performed on January 24, 2011 and the findings were reported as negative. There was no bony injury, no ligamentus disruption, and no internal derangement detected.

The petitioner underwent a functional capacity evaluation on March 21, 2011. This evaluation was performed at Priority Physical Therapy and it was determined that the petitioner put forth a full and consistent effort during the evaluation. It was determined that the petitioner was capable of performing within the medium physical demand level and that he could perform at 72% of the physical demand of his job as a heavy equipment operator.

On May 16, 2011, Dr. Rubinstein concluded that the petitioner was at maximum medical improvement and that the petitioner could return back to work within the abilities mentioned in the functional capacity evaluation which restrictions would be on an ongoing and permanent basis.

On October 27, 2011, the petitioner underwent another independent medical evaluation with Dr. Kodros Dr. Kodros reviewed complete medical records, including those records reflecting treatment prior to the work injury. Dr. Kodros concluded that the petitioner had ongoing left foot and ankle complaints which were not readily explained by any identifiable musculoskeletal orthopedic foot or ankle condition. He concluded that the petitioner's condition appeared to be complicated by chronic opioid dependency, given the amount and duration of his narcotic pain medication usage based on a review of the record. He concluded that the severity of the petitioner's subjective complaints was not readily supported by objective findings and evaluation. He concluded that the petitioner had reached maximum medical improvement relative to the ankle sprain by the end of August, 2010. He was unable to say within a reasonable degree of medical and surgical certainty whether there was a causal relationship between his current left ankle problems and complaints and the original work injury. He did not believe that the left ankle condition required specific restrictions.

On November 5, 2010, at the referral of Dr. Rubinstein, the petitioner began treating with Dr. Artelia Watson, a pain management physician. Dr. Watson assessed the petitioner with lumbar spinal stenosis and lumbar radiculitis. At that time, he suggested that the petitioner continue Vicodin and Gabapentin. He recommended lumbar epidural steroid injections. Thereafter, the petitioner treated with Dr. Watson from November 5, 2010 through June 30, 2015. Throughout that period of time, Dr. Watson has performed epidural steroid injections and has prescribed narcotic medication. Dr. Watson has concluded that the petitioner is permanently and totally disabled. Dr. Watson disagreed with the FCE conclusion releasing the petitioner to return to work at the medium level capacity. Dr. Watson agreed that he has continued to prescribe narcotic medication for the petitioner for almost five years based on the petitioner's subjective complaints and he further admitted that his basis for concluding that the petitioner is permanently and totally disabled is based on the petitioner's description of his pain.

On November 27, 2012 the petitioner was examined at the request of the respondent by Dr. Kevin Walsh. Dr. Walsh reviewed all of the petitioner's medical records, both before petitioner's accident and after, and concluded that it was not at all likely that the petitioner's current subjective complaints were causally related to the work accident of April 21, 2010. Dr. Walsh concluded that the petitioner was at MMI and that no additional orthopedic or medical intervention was needed or advised. Dr. Walsh opined that it was not at all likely that the petitioner suffered a low back injury during the incident of April 21, 2010. Dr. Walsh cited petitioner's failure to complain of low back complaints to Centegra, as well as Dr. Virkus. Dr. Walsh also cited the records of Dr. Chibber confirming that the petitioner was receiving narcotic medication from his primary care physician prior to the work injury. Dr. Walsh concluded that, at most, the petitioner suffered a knee and foot sprain. He further opined that the petitioner's subjective complaints were out of proportion to the diagnosis rendered in the medical records. He placed no work restrictions upon the petitioner as a result of the work injury. He concluded that the petitioner requires no current treatment and is at maximum medical improvement from his injuries.

Thereafter, Dr. Walsh reviewed the MRIs of the petitioner's lumbar spine, both before and after the work injury. He concluded that the post-accident MRI was essentially the same as the MRI done prior to the accident relative to the lumbar spine. He concluded that there were no findings on the MRI of 2010 which can be specifically attributed to a traumatic event and opined that all of the MRI findings were consistent with degenerative disease. Relative to the MRI of the petitioner's left knee

performed in May of 2010, Dr. Walsh concluded that the MRI findings revealed evidence of a Grade II sprain of the medial collateral ligament and a bone contusion. He concluded that these findings would heal non-operatively. Dr. Walsh also reviewed a second MRI of the petitioner's knee, which was performed on January 24, 2011, and he concluded that the MRI was essentially normal. Dr. Walsh reviewed the MRI of the petitioner's left ankle, which was performed on May 3, 2010 and concluded that the MRI was essentially normal. Dr. Walsh confirmed the opinions that he had expressed following his independent medical evaluation, concluding that the petitioner required no additional orthopedic or medical intervention as a result of his injury of April 21, 2010. He concluded that the petitioner had reached pre-injury status.

The respondent presented the testimony of Lawrence Grott, an investigator who was hired by the respondent to perform surveillance upon the petitioner. Mr. Grott testified to several different days of surveillance performed between the dates of March 20, 2015 and April 14, 2015. Mr. Grott's testimony was further supplemented by Respondent's Exhibits 20 and 21, which contain a summary of Mr. Grott's observations on the dates enumerated therein. The petitioner categorically denied that he was the individual depicted in the surveillance video that was also introduced into evidence as Respondent's Exhibit 22. Mr. Rickie Gary testified on behalf of the petitioner. He testified that he is the individual depicted on the several days of the video that were captured by Mr. Grott. Mr. Grott testified after observing both the petitioner and Mr. Gary in the courtroom that he is certain that he captured video of the petitioner and not Mr. Gary. The activities depicted in the video are inconsistent with petitioner's description of his daily activities, as the petitioner claims he spends the majority of each day, in bed.

Petitioner's Exhibit 12 reflects an itemization of medical bills incurred by the petitioner subsequent to the work event of April 21, 2010. This itemization reflects that the medical bills at Accelerated Rehabilitation Centers have been paid in full. In addition, the medical bills of Midwest Orthopaedics at Rush have also been paid in full. The majority of the remaining balance of $144,277.56 reflects treatment from various providers relative to petitioner's low back condition. Lakeside Eye Group, in the amount of $930.00, involves treatment to petitioner's left eye. Further, the bill of Illinois Bone & Joint Institute, in the amount of $1,106.00, reflects a combination of treatment to petitioner's left knee, left ankle, and low back. However, the bill reflects that the remaining balance was for treatment after October 13, 2010. The remaining bills reflect treatment exclusively to petitioner's low back.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

It is axiomatic that the Petitioner bears the burden of proving all of the elements of his claim by a preponderance of the credible evidence. The Arbitrator finds that the petitioner failed to prove that his current low back condition is causally related to the work accident of April 21, 2010. In so finding, the Arbitrator notes that the petitioner's testimony that his pre-existing low back condition had

resolved prior to the work accident of April 21, 2010 and only required an occasional Vicodin is not supported by the medical evidence. In fact, the petitioner was treating with Dr. Chibber on an ongoing basis prior to the work accident. Such treatment included regular refills of Vicodin, accompanied by complaints of low back pain. The petitioner was refilling the Vicodin at such a rate that he was averaging two and one-half Vicodin tablets per day.

The Arbitrator also notes that, significantly, when the petitioner first sought treatment following the work accident he made no complaints of back pain. At Centegra on April 22, 2010, the petitioner complained of significant left knee pain and left ankle pain but he offered no complaints of pain relative to the low back. Similarly, when the petitioner sought treatment with Dr. Chibber on April 22, 2010, he complained of left knee and ankle pain but offered no complaints of pain relative to the low back. It was not until May 27, 2010 that the petitioner apparently asked Dr. Chibber to amend his earlier records to reflect complaints of back pain and the doctor then did so. Further, when the petitioner sought treatment with Dr. Virkus on April 28, 2010, he complained of left knee, left shin, left ankle, and left foot pain. He offered no complaints of pain relative to the low back.

The Arbitrator further notes that the petitioner treated with Dr. Variakojis, from December 2008 through February 2009 and that Dr. Variakojis had ordered an MRI of the lumbar spine. That MRI was conducted on December 18, 2008. That MRI, when compared with a post-work-related injury MRI of September 20, 2010, revealed no difference in terms of findings. Both MRIs revealed that the petitioner suffers from significant degenerative disc disease within the lumbar spine.

Dr. Kevin Walsh testified that there was no evidence in the medical records that the petitioner injured his lower back in the work accident of April 21, 2010. Dr. Walsh testified that if the petitioner had injured his lower back, the records of Concentra (meaning Centegra) and Dr. Virkus would indicate a low back injury. Dr. Walsh testified that it was not likely at all that the petitioner would present to Centegra or the office of Dr. Virkus and have an injury to his back that was missed because he had a leg and ankle symptoms. The Arbitrator finds it difficult to believe that had the petitioner complained of lower back symptoms when he was initially seen at Centegra, and by Dr. Virkus, that those complaints would not be noted in the medical records of those visits.

The Arbitrator notes that while there is a reference to back pain in the April 29, 2010 Accelerated Rehabilitation Physical Therapy records, the specific diagnosis that is listed in such records is simply a sprain and strain to the knee, leg, and ankle. The physical therapy records themselves only reflect treatment to the petitioner's leg and ankle.

Dr. Salehi, who examined the petitioner on October 28, 2010, concluded, among other things, that he believed the petitioner sustained a lumbar strain or at most a temporary exacerbation of a pre-existing condition relative to the low back. Dr. Salehi concluded that the petitioner would have reached maximum medical improvement from such an injury within three months of the date of injury.

The Arbitrator also notes that the petitioner's description of the work incident started as a burst hose which sprayed him with oil and struck his left leg, and eventually became an "explosion" which knocked him into a machine. Dr. Virkus, the Petitioner's treating physician, also questioned the legitimacy of the petitioner's complaints noting that they seemed "a bit contrived", that they outweighed the physical examination, that they were "unusual" and that there were no objective

findings to correlate with the petitioner's subjective complaints. Thus, the Arbitrator concludes that the petitioner is prone to exaggeration and that the veracity of his complaints to his physicians, and at trial, is subject to question.

Relative to petitioner's left knee and ankle, the Arbitrator does find that a causal relationship exists between the work injury of April 21, 2010 and a left knee and left foot sprain.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The petitioner was prescribed off work when he initially sought treatment at Centegra on April 22, 2010. The petitioner then treated with Dr. Virkus who diagnosed a left knee and ankle sprain and continued the petitioner off work. As of July 14, 2010, Dr. Virkus concluded that he had no idea what was going on with the petitioner as he could find no objective evidence to correlate with the petitioner's subjective complaints and there were no radiographic studies that correlated with the petitioner's complaints. Dr. Virkus released the petitioner to a functional capacity evaluation as of July 14, 2010, and indicted that he was likely at maximum medical improvement.

Dr. Kodros examined the petitioner at the request of the respondent on July 14, 2010 and October 27, 2011. Dr. Kodros noted that the petitioner had ongoing left foot and ankle complaints which were not readily explainable by any identifiable musculoskeletal orthopedic foot or ankle condition. Dr. Kodros could not say within a reasonable degree of medical and surgical certainty whether or not a causal relationship existed between the left ankle problems and complaints and the injury that occurred on April 21, 2010. Dr. Kodros did not find an indication for further orthopedic treatment for the petitioner's left ankle condition. Dr. Kodros concluded that the indication for activity restrictions appeared to be purely based on limitations that were secondary to ongoing subjective pain complaints. He further stated in his report of October 27, 2011 that the petitioner had reached maximum medical improvement relative to his ankle sprain by the end of August, 2010.

Dr. Salehi examined the petitioner on October 28, 2010. He concluded that petitioner would have reached maximum medical improvement relative to a lumbar strain within three months from his date of injury. He released the petitioner to return to work in a light-duty capacity and suggested a functional capacity evaluation. He did not believe, however, that the functional capacity evaluation was related to the work injury but rather to the pre-existing lumbosacral condition. The Arbitrator finds the opinions of Dr. Virkus, Dr. Kodros, and Dr. Salehi to be credible, reliable, and persuasive in the instant matter. The Arbitrator adopts the combined opinions of Drs. Virkus, Kodros, and Salehi and finds that the Petitioner reached maximum medical improvement from his work related injuries by August 31, 2010. Accordingly, the Arbitrator finds that the petitioner is entitled to Temporary Total Disability benefits from April 22, 2010 through August 31, 2010. The Arbitrator finds that the petitioner failed to prove that any period of temporary disability after August 31, 2010 is causally related to the work accident of April 21, 2010.

Based upon the foregoing, the Arbitrator finds that petitioner is entitled to temporarily totally disability benefits from April 22, 2010 through August 31, 2010, a period of 18-6/7 weeks.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Arbitrator has concluded that the petitioner failed to prove that his low back condition is causally related to the work accident of April 21, 2010. Accordingly, any treatment rendered to the petitioner relative to the low back condition, is not causally related to the work accident and is therefore not awarded to the petitioner. A review of Petitioner's Exhibit 12 reveals that the bills of Accelerated Rehabilitation Centers, which was for physical therapy to petitioner's left knee and left ankle, as well as the bill of Dr. Virkus, which was also for treatment to petitioner's left leg and left ankle, have been paid in full. However, the parties agreed that, in the event that such charges were paid through private health insurance, respondent shall hold petitioner harmless from any claim for reimbursement made by such group carrier for such bills to the extent of the Illinois Medical Fee Schedule or negotiated rate, whichever is less. All other bills submitted by the petitioner are either related to petitioner's low back, which the Arbitrator has concluded is unrelated to the work accident, or were incurred after August 31, 2010, the date by which the Arbitrator has found that the petitioner reached maximum medical improvement. For this reason, all such bills are denied in their entirety.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

Relative to petitioner's left knee, the petitioner sustained a Grade II left knee strain. Numerous MRIs and x-rays were taken which revealed nothing more than a resolved contusion and a healed medial collateral sprain, with no residuals.

With regard to petitioner's left ankle, the Arbitrator finds that the petitioner suffered a left ankle sprain, with no significant MRI findings.

Accordingly, the Arbitrator hereby awards the petitioner 5% loss of use of the left leg and 5% loss of use of the left foot.

With regard to petitioner's low back, the Arbitrator has already concluded that the petitioner failed to prove that a causal relationship exists between the petitioner's low back condition and the work accident. Accordingly, the petitioner has suffered no permanent partial disability to his low back relative to the work accident of April 21, 2010.

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

William M. Sloan,

Petitioner,

vs.

NO: 15WC 27631

Kone Elevators and Escalators,

18IWCC0193

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 20, 2016 is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 29 2018

Charles J. DeVriendt

Joshua D. Luskin

o013118
CJD/rlc
049

DISSENT

A claimant who suffers from a pre-existing condition may recover benefits under the Act where an accident aggravates or accelerates his condition. *International Vermiculite Company v. The Industrial Commission*, 77 Ill. 2d 1 (1979). Further the accident must be a factor which contributes to the disability. *Caterpillar Tractor Co. v. The Industrial Commission*, 92 Ill. 2d 30 (1982). Mere correlation of symptoms is not enough as causation between the accident and the resulting disability must exist. *Long v. The Industrial Commission*, 76 Ill. 2d 561 (1979). No such causation exists. Therefore, I respectfully dissent.

Petitioner testified he stepped into a hole causing his right knee to buckle with immediate pain. T. 17-18. On March 30, 2015 Petitioner underwent an MRI which evidenced injury to a previous ACL graft as well as tearing of the medial meniscus, likely degenerative. PX2. Thereafter on April 13, 2015 Petitioner presented to Dr. Watson who previously performed an ACL reconstruction on Petitioner's right knee in 1997. PX3, p. 22. Dr. Watson diagnosed Petitioner with osteoarthritis of the right knee as well as an acute injury. Dr. Watson recommended arthroscopic surgery and commented regardless of treatment, Petitioner would

eventually need a knee replacement. Dr. Watson's diagnoses were 1) acute medial meniscus tear; 2) acute lateral meniscus tear; and 3) osteophytosis. PX3. On May 14, 2015 Dr. Watson performed arthroscopic surgery to repair the acute menisci tears and a chondroplasty for the osteoarthritis. PX4. On June 3, 2015 Dr. Watson re-evaluated Petitioner and recommended physical therapy. PX3. On June 5, 2015 Petitioner attended physical therapy with a recommendation for two times per week for four weeks. PX6. On June 19, 2015, Dr. Watson re-evaluated Petitioner and recommended abstaining from physical therapy for a week. Thereafter Petitioner failed to return to physical therapy and is discharged due to non-compliance. PX6. On June 23, 2015 Dr. Watson re-evaluated Petitioner who is complaining of increased pain and requests knee replacement surgery. As such Dr. Watson recommends the same. PX3. On July 8, 2015 a Utilization Review finds the knee replacement surgery is non-certified. RX3. On August 5, 2015, Dr. Watson re-evaluated Petitioner who complains of ongoing pain and inability to walk without crutches except for short distance. Dr. Watson continues to recommend a total knee replacement and authorizes Petitioner off work. PX3. Thereafter Petitioner returns to work full duty a week later on August 12, 2015.

Surveillance video records Petitioner on several occasions: July 21, 2015; August 28, 2015; and September 23, 2015. Petitioner is not observed using crutches nor is there any visible altered gait. RX4-6.

On July 20, 2015, Petitioner is evaluated by Dr. Lawrence Li pursuant to Section 12 of the Act at request of Respondent. On August 13, 2015, Dr. Li authors a report wherein he diagnosed Petitioner with osteoarthritis and opined Petitioner's injury temporarily aggravated his condition leading to the need for the arthroscopic surgery. Dr. Li further opined such conditions resolved, and Petitioner's current condition was unrelated with no additional treatment indicated. RX2.

Dr. Li provided testimony *via* evidence deposition on July 25, 2016. RX1. Dr. Li testified consistent with his report stating: "I feel that the work injury caused an aggravation of his meniscus tear that required him to have arthroscopic surgery to address it, but I don't think that the injury contributed at all to the osteoarthritis that he has currently because that takes decades and would not be, would not be accelerated by this type of injury." RX1, p. 15. Dr. Li

also reviewed the surveillance video and testified as follows: "Also, I had reviewed a surveillance video that really was not consistent with what Mr. Sloan told me that he was capable of doing. So I felt that—frankly I questioned his honesty on this. I don't feel that any additional treatment would be needed for this work injury." RX1, p. 17.

Dr. Watson provided testimony *via* evidence deposition on December 16, 2015. PX7. Dr. Watson testified Petitioner's accident aggravated the underlying osteoarthritis as well as the meniscal tears. PX7, p. 19. Dr. Watson further testified as to the basis of his opinion stating: "Mostly his symptoms. We don't know exactly how bad it was prior to the work injury, but I do know, if he is telling me the truth, that he was working without symptoms; he wasn't missing any work; wasn't having any specific troubles. And then he had this injury. And at that point in time, then really up until this date, he's had problems with it. So it's that rather than what I am looking at on the x-rays or the scope that makes me believe that that injury did something to him to make his problems worse." PX7, p. 20. Dr. Watson testified at the post-op visit of June 23, 2015, five and a half weeks post-surgery, Petitioner began inquiring as to a knee replacement. Dr. Watson explained since Petitioner understood a knee replacement was inevitable, Petitioner's rationale for having such procedure now was two-fold: 1) returning to work on an expedited basis; and 2) the intricacies of the workers' compensation system in obtaining authorization of the surgery. PX7, p. 23-24. Dr. Watson testified as to his criteria for recommending surgery being symptoms, ability to function, age, desire for the surgery, and significant pathology of which Dr. Watson was only aware of Petitioner's age as he had not evaluated Petitioner since August 5, 2015. PX7, p. 54-55.

I would afford greater weight to the opinion of Dr. Li who possessed a greater understanding of Petitioner's overall condition. Petitioner suffered an accident which caused an acute trauma leading to the need for arthroscopic surgery to repair meniscal tears. Without attending the recommended course of physical therapy, Petitioner presented to Dr. Watson on June 23, 2015 requesting a knee replacement as such surgery was inevitable given Petitioner's pre-existing condition. Dr. Watson recommends the same given Petitioner's request and ongoing complaints. Dr. Watson testified his recommendation was based upon Petitioner's subjective complaints and his desire to return to work.

Dr. Watson unlike Dr. Li did not have a complete understanding of Petitioner's condition. Petitioner returned to work full duty as of August 12, 2015. Further the video surveillance evidenced Petitioner walking without difficulty despite his history to Dr. Watson of needing crutches to walk. The video surveillance further evidences Petitioner performing work on a farm which Petitioner admitted to performing. Dr. Watson's causation opinion is predicated on Petitioner being truthful which he was not. Dr. Li had the benefit of the video surveillance and therefor an accurate understanding of Petitioner's condition.

As the Court noted in *Sisbro Inc. v. The Industrial Commission*, 207 Ill. 2d 193, 212-13 (2003):

> Every employee whose disease or preexisting condition disables him while at work is not automatically entitled to a recovery under the Workmen's Compensation Act. In *Carson-Payson Co. v. Industrial Com. (1930), 340 Ill. 632, 639, 173 N.E. 184*, this court said, quoting from Lord Chancellor Loreburn's opinion in *Hughes v. Clover, Clayton & Co.* (1910), 102 L.T.R. 340, 342, *aff'g* (1909) 2K.B. 798, 101, L.T.R. 475: "In each case the arbitrator ought to consider whether, in substance, as far as he can judge on such a matter, the accident came from the disease alone, so that, whatever the man had been doing, it would probably have come all the same, or whether the employment contributed to it. In other words, did he die from the disease alone, or from the disease and employment taken together, looking at it broadly. *County of Cook, 68 Ill. 2d at 31-31.*"

Petitioner's current condition of ill-being was caused by his degenerative condition and not his work-related meniscal tears. I would find Petitioner at MMI as of July 14, 2015 based upon the opinion of Dr. Li and deny any medical expenses and temporary total disability benefits thereafter. Accordingly, I dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

SLOAN, WILLIAM
Employee/Petitioner

Case# **15WC027631**

KONE ELEVATOR & ESCALATORS
Employer/Respondent

18IWCC0193

On 10/20/2016, 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 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2427 KANOSKI BRESNEY
THOMAS R EWICK
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

1109 GAROFALO SCHREIBER STORM
DAVID HANSON
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION
19(b)

William M. Sloan
Employee/Petitioner

Case # 15 WC 27631

v.

Consolidated cases: N/A

Kone Elevators & Escalators
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 **August 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **3/12/15**, 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 **$84,557.22**; the average weekly wage was **$1,626.10.**

On the date of accident, Petitioner was **48** years of age, ***married*** with **0** dependent children.

Petitioner was temporary totally disabled from **May 14, 2015** through **August 12, 2015** a period of **13 weeks.**

Respondent shall be given a credit of **$10,000.36** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$10,000.36.**

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

Respondent is entitled to a general credit for any medical bills it has paid through its group medical plan for which credit is allowable under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of **$27,130.12** as set forth in Petitioner's Exhibit No. 8 consistent with the Medical Fee Schedule for necessary medical services, as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical bills that have been paid by its group health insurer, and Respondent shall hold Petitioner harmless for any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Petitioner is awarded prospective care in the form of a follow-up office visit with Dr. Watson. Petitioner's request for prospective medical care in the form of a total knee replacement is denied at this time.

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 16, 2016
Date

ICArbDec19(b)

OCT 20 2016

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner sustained a previous injury to his right knee in 1997 when he fell seventeen feet down an elevator shaft. Petitioner underwent full reconstructive surgery for his knee with Dr. Watson. (PX 1)

Petitioner began working for Respondent in 2011 as an elevator mechanic. As such, he constructs, repairs, and maintains elevators. (PX 1)

Petitioner testified, and the records confirm, that on March 12, 2015, he was installing an elevator at Memorial Medical Center in Springfield, Illinois. The elevator was being installed on top of an old roof as part of a construction project. Petitioner stated that he was carrying an extension ladder and stepped in a hole which he did not see with his right leg. The hole was about 16 inches around and 3 to 4 inches in depth. He noted his leg buckled and he "went down.". Afterwards, he noticed a sharp pain in his right knee. Respondent does not dispute that Petitioner sustained an accident.

Following the accident, Respondent referred Petitioner to Midwest Occupational Health Associates (MOHA), on March 26, 2015. Petitioner gave a consistent history of his accident and further noted that since the accident he had been experiencing swelling and pain in his knee, which was getting worse. He also reported that his knee was starting to give out on him. He described a stabbing pain along his inner knee area. An MRI was recommended, and he was given a work restriction of no ladder climbing along with a prescription for Naproxen. (PX1)

On March 30, 2015, an MRI of Petitioner's right knee was performed. The radiologist's impressions were as follows: (1) moderate grade injury to the ACL graft; (2) extensive complex tearing involving the body and posterior horns of the medial meniscus, likely related to degenerative osteoarthrosis; (3) extensive cartilage loss at the medial femorotibial compartment with reactive edema within the distal medial femoral condyle and medial tibial plateau; and (4) small joint effusion. (PX 1; PX2)

Following the MRI, MOHA referred Petitioner to Dr. Watson. (PX 1; PX3, p. 105)

On April 13, 2015, Petitioner presented to Dr. Watson, where he gave a history of twisting his right knee when stepping on the side of a hole on March 9, 2015. Petitioner reported experiencing immediate medial joint line pain and difficulty walking. However, he did not report the injury immediately until co-workers noticed he was limping for a week or so. Dr. Watson noted that he had previously performed an ACL repair on Petitioner and that Petitioner had an excellent outcome from the procedure and had been asymptomatic up until this most recent injury. Petitioner was continuing to work and preferred not to have any restrictions. Dr. Watson reviewed Petitioner's MRI which suggested the anterior cruciate ligament graft might be loose. He also noted complex tears of Petitioner's menisci and multiple osteophytes. Petitioner's physical examination documented an antalgic gait, tenderness in the medial joint line, pain with valgus stress, positive Lachman's test, positive McMurray's test, and moderate-sized effusion. X-rays showed moderately severe degenerative changes in the medial joint line with multiple osteophytes. Dr. Watson's impression was osteoarthritis of the knee with an acute injury causing exacerbation. They discussed medications, injections and arthroscopic surgery. Dr. Watson

recommended an arthroscopy. He also noted that Petitioner understood that it was likely that, at some point in time, he would need a total knee replacement regardless of his treatment at the present time. Petitioner was allowed to continue working without restrictions. (PX3, p. 14/107)

Petitioner was cleared for surgery on May 1, 2015. (PX 6, p. 16)

Petitioner's arthroscopic surgery was approved and on May 14, 2015, Dr. Watson performed a diagnostic arthroscopy with partial medial and lateral meniscectomies and chondroplasty. According to the operative report, Dr. Watson noted the undersurface of Petitioner's patella revealed areas of grade 2 and grade 3 chondromalacia as well as the intercondylar notch. A complete chondroplasty was performed. Dr. Watson also observed a complex posterior horn tear of the medial meniscus requiring a partial meniscectomy with an arthroscopic shaver and meniscal baskets and a posterior horn radial tear of the lateral meniscus which was partially excised. The previously reconstructed anterior cruciate ligament graft appeared loose but was intact. Dr. Watson's post-operative diagnoses were medial and lateral meniscus tears with grade 3 chondromalacia of the medial femoral condyle and patellofemoral joint. (PX 3, pp. 80-81/107; PX4)

On May 20, 2015, Dr. Watson re-examined Petitioner and they discussed the surgical findings. Petitioner still had some mild swelling about his knee. Petitioner was allowed to return to work but only on a sedentary basis and he would require crutches for ambulation. Petitioner also required narcotic pain medication for which Dr. Watson advised him not to drive. Formal therapy was to begin. (PX3, pp. 13, 70-72)

On June 1, 2015 Respondent inquired as to Petitioner's ability to return to work in some capacity. Dr. Watson responded with a script indicating he could not drive while taking narcotics and could not do so until cleared. (PX 3, p. 12, 70/107)

On June 5, 2015, Petitioner presented to St. John's TherapyCare for a physical therapy evaluation. He reported that his right knee was more painful than it was prior to the arthroscopy. Petitioner remarked that he had been told there was a lot of "bone on bone" in his right knee and that he might be a candidate for a knee replacement if this was unsuccessful. He complained of a sharp pain in the medial and subpatellar aspect of his right knee. (PX 3, p. 64107; PX5, p. 97) Petitioner was reportedly severely limited in his ability to walk or use stairs. The therapist recorded Petitioner's gait pattern was moderately antalgic on the right with use of bilateral axillary crutches and decreased knee flexion. Physical examination showed his patellar mobility, quadriceps motor control, and straight leg raise were poor on the right. (PX5, pp. 98-99) It was recommended that he participate in physical therapy 2 times a week for 4 weeks. (PX5, p. 100)

On June 8, 2015, Petitioner's therapist recorded that Petitioner was reporting moderate right knee pain with a tearing sensation for which he was going to try to see Dr. Watson. Therapy was placed on hold until Petitioner spoke with Dr. Watson. (PX4, p. 94/107)

On June 9, 2015, Dr. Watson re-examined Petitioner noting worsening knee pain. Petitioner had been compliant with physical therapy but his anterior knee pain was becoming so severe that he was not getting much accomplished with physical therapy. Dr. Watson suspended physical therapy for one week. He noted, "Petitioner remains on crutches." (PX3, p. 10/107)

On June 11, 2015 St. John's TherapyCare confirmed with Petitioner that Petitioner had seen Dr. Watson and the next three appointments had been canceled. Petitioner was going to attempt to return to therapy on June 22, 2015. (PX 5, p. 92)

Petitioner did not show up for therapy on June 22, 2015. (PX 5, p. 91)

On June 23, 2015 the therapist's office tried to contact Petitioner to confirm his appointment that day but was unable to reach Petitioner. Petitioner's doctor's office was called and the clerk confirmed that Petitioner was to be continuing services at that time but that not showing up for appointments was not unusual. Dr. Watson's clerk and the therapist agreed to a plan of attendance and potential discharge for Petitioner if he did not attend his appointment. (PX 5, p. 90)

On June 23, 2015, Dr. Watson re-examined Petitioner, noting Petitioner's pain was actually worsening and he was unable to ambulate with full weight bearing and required crutches. Petitioner was having difficulty sleeping and pain medication was of no relief. Dr. Watson noted considerable tenderness in Petitioner's medial femoral condyle which was the area of his grade IV chondromalacia. His Lachman's test was 2+ positive. Dr. Watson noted Petitioner was losing some quadriceps strength and had mild atrophy. According to the doctor's office note, "[Petitioner] was now inquiring about knee replacement surgery. He feels that this is inevitable and for that reason he does not want to wait." Dr. Watson indicated he would seek authorization for a right knee replacement surgery. Petitioner was advised that if for some reason he should improve or his pain diminish the plans for surgery would be canceled. Petitioner's work restrictions remained unchanged. He remained on Norco. (PX3, pp. 8-9, 59/107)

On June 24, 2015 Dr. Watson's office was advised that no surgery would be authorized at that time as Respondent's insurance carrier was proceeding to schedule an IME. (PX 3, p. 56)

A June 24, 2015 physical therapy note to Dr. Watson advised the doctor that Petitioner had not shown up for his last two appointments and if he missed two more, he would be discharged as non-compliant. (PX 3, p. 16/107)

On June 28, 2015 Petitioner was placed under surveillance. Petitioner is seen driving to Springfield, walking and standing around a botanical garden carrying a backpack without the use of crutches, braces, supports or other orthopedic devices. (RX 7, RX 4)

Petitioner was discharged from therapy on June 29, 2015 as he failed to show up for his last two appointments. (PX 3, p. 54/107; PX 5, pp. 88-89)

Utilization Review denied certification for knee replacement surgery in a report dated July 1, 2013 authored by Dr. Dunbar. Surgery was not certified as Petitioner was less than 50 years of age, only 5 ½ weeks post right knee arthroscopy, lacked any documented decreased range of motion of less than 90 degrees, and there were no imaging and clinical findings revealing significant loss of chondral clear space and "at least 1 of the 3 compartments or previous arthroscopy documented in advanced chondral erosion or exposed bones." (PX 3, pp. 46-52/107) He further noted that the guidelines required attempts at conservative care such as physical therapy, NSAIDs, viscosupplementation or steroid injections as well as documentation of current functional limitations. (Id.)

On July 1, 2015 Dr. Watson's office noted that the doctor had received a voicemail at 11:20 a.m. that morning requesting a peer to peer review with Dr. Dunbar concerning the request for knee replacement surgery. The voice mail indicated the peer to peer would expire at noon today. Dr. Watson's office contacted the woman at 12:08 to see if an extension could be granted since the doctor had already left the office for a prior noon appointment. Dr. Watson's office was advised that Dr. Dunbar didn't have authority to grant extensions. In turn, the doctor's office noted that Dr. Watson would be returning on July 6th and left the doctor's number and patient's name. (PX 3, p. 7/107)

On July 4, 2015 Dr. Watson provided additional information regarding the utilization review on Petitioner. He described the accident and Petitioner's prior 1997 injury from which he noted Petitioner had been asymptomatic for quite some time. Dr. Watson discussed the 2015 arthroscopic surgery which, he stated, revealed extensive damage to the articular cartilage of Petitioner's tibial plateau. Petitioner had a large cartilage flap tear with exposed subchondral bone. A significant chondroplasty was performed but Petitioner's pain remained. Despite narcotic pain medications, intra-articular injections, and extensive physical therapy Petitioner failed to improve and, in fact, had worsened. According to Dr. Watson, Petitioner's only remaining option was knee replacement surgery. Dr. Watson felt Petitioner had failed conservative treatment and the photographs taken during surgery clearly showed significant loss of chondral tissue with narrowing of the joint space as required by guidelines. While Petitioner's motion was noted to be 110 degrees with significant pain, the doctor could not understand why knee replacement surgery was being denied to someone who had more than 90 degrees of flexion as he didn't believe he had ever performed a knee replacement on someone with less than 90 degrees of flexion. Dr. Watson noted that even most people with advanced osteoarthritis are surely able to flex at least 90 degrees. Dr. Watson further stated that since Dr. Dunbar was recommending viscosupplementation prior to knee surgery, he was optimistic that same would be authorized if surgery was denied. Finally, while criteria cited by Dr. Dunbar required that a patient be over 50, Petitioner was 49 and currently unable to return back to work with his current condition. Dr. Watson felt the best possible chance for Petitioner to return to work with no or minimal restrictions would be after knee replacement surgery. (PX 3, pp. 43-44/107)

On July 8, 2015 Dr. Dowd issued his report advising Dr. Watson that the total knee replacement procedure he had recommended was not being certified. He indicated that under the Official Disability Guidelines-Treatment for Workers' Compensation, the criteria for a knee joint replacement are: (1) conservative care (exercise therapy, medications, viscosupplementation or steroid injections); (2) subjective clinical findings (limited range of motion); (3) objective clinical findings (over 50 years of age and body max index less than 35); and (4) imaging clinical findings (osteoarthritis documented on x-rays or a previous arthroscopy documenting advanced chondral erosion or exposed bone). (RX3) In the report, Dr. Dowd stated the records he reviewed[1] did not contain specific objective and radiographic findings suggesting severe osteoarthritis and there was no evidence that Petitioner failed to respond to physical therapy, bracing or corticosteroid injections. Based upon the information provided to him, Dr. Watson was advised that Dr. Dowd had determined that the need for a total knee replacement had not been medically documented. In his report, Dr. Dowd noted, in particular, that the mechanism of injury was not provided. Petitioner had not completed conservative care and Petitioner was under the age of 50. Dr. Dowd could not find any evidence of specific objective and radiographic findings of severe osteoarthritis or evidence of Petitioner's failure to respond to physical therapy, bracing or corticosteroid injections prior to a total knee replacement procedure. Dr. Dowd had reviewed three office notes of Dr. Watson including office visits of 5/20/15, 6/23/15, and 6/3/15. He had also discussed the matter with Dr. Watson who had no additional clinical information to provide. (RX 3; PX 3) No appeal was taken.

Video surveillance of Petitioner was taken on July 8 and 9, 2015 with no video obtained. (RX 4, 7)

Dr. Watson re-examined Petitioner on July 14, 2015 noting no change in Petitioner's symptoms or examination. Petitioner was scheduled for an IME and authorization to proceed with knee replacement surgery was pending. He was to return in three weeks. (PX 3, p. 6/107)

Petitioner was again under surveillance on July 14, 2015 at which point he is seen driving a truck, going to the post office, walking in a fluid motion, and exiting his vehicle to walk in a cornfield. At no time was Petitioner using crutches or any assistive devices. (RX 7, RX 4)

[1] 9 pp. including o/v with Dr. Watson on 5/20/15, 6/3/15, and 6/23/15

Petitioner was examined by Dr. Lawrence Li on July 20, 2015.

Petitioner was cleared for knee replacement surgery by his family doctor on July 24, 2015. Petitioner had lost twenty pounds by dieting. He remarked to his doctor that the surgery had not been scheduled but Dr. Watson wanted it "now" as a more conservative approach had been unsuccessful. (PX 6, p. 10)

On August 5, 2015, Petitioner returned to see Dr. Watson. Dr. Watson recorded that Petitioner's symptoms and exam were unchanged. Petitioner reported being unable to walk without crutches except for very short distances and he was having difficulty sleeping because of pain. Noting Petitioner's knee replacement had been denied, Dr. Watson indicated he would attempt to get Hyalgan injections authorized. Petitioner remained off work. He was given a script for Norco. Petitioner was to return in one month. (PX3, pp. 4-5, 36/107)

Dr. Li issued his written report on August 13, 2015 (based upon his 7/20/15 exam) addressing Petitioner's knee and various medical-legal questions. Dr. Li noted that Petitioner was carrying a ladder on/about March 9, 2015 when he stepped into a hole and twisted his knee. He continued working and worked for more than a week afterwards when he then reported the incident and went to see Dr. Bower, his primary care physician, regarding persistent swelling and pain. Dr. Li did not have the actual MRI images taken on March 30, 2015 to review but, rather, relied upon the report. He understood Petitioner ultimately underwent surgery which showed medial and lateral meniscal tears with grade III chondromalacia in the medial femoral condyle and patellofemoral joint. The ACL graft that had been previously performed by Dr. Watson in 1997 was slightly loose but, otherwise, intact. Petitioner tried therapy after surgery but it was stopped due to persistent pain. Petitioner told Dr. Li that he did not have any problems with his knee after the 1997 surgery until this most recent accident. Petitioner also told the doctor that when he first met with Dr. Watson in April of 2015 Dr. Watson told him the surgery was worth a try but probably wouldn't be effective and he would inevitably need a knee replacement. (RX 2, pp. 1-3)

At the time of the examination Petitioner was taking hydrocodone for pain. He had not undergone any injections nor was he on any anti-inflammatory medication. He reported medial knee pain and that he had to use crutches when on any type of uneven ground or walking long distances. He also reported pain in his right knee with any type of movement and extensive walking and uneven ground. (RX 2, p. 2)

On examination Dr. Li noted that any attempt at McMurray testing medially or laterally caused severe pain. Dr. Li also reviewed Petitioner's x-rays of Petitioner's knee and agreed it showed an ACL reconstruction and bone-on-bone on the medial joint line. Dr. Li was of the opinion that, as a result of the accident, Petitioner suffered a temporary aggravation of pre-existing osteoarthritis and degenerative meniscal tears in his right knee. He felt Petitioner's current diagnosis was osteoarthritis. He did not feel that Petitioner's accident contributed at all to Petitioner's current diagnosis. He felt the work accident temporarily aggravated the underlying pre-existing osteoarthritis and degenerative meniscal tears to a point that arthroscopic surgery was required but that Petitioner had healed from the meniscectomies and the work accident no longer contributed to the current osteoarthritis. Dr. Li further opined that Petitioner's osteoarthritis was long-term and was evidenced on the x-rays and MRI report. He felt Petitioner's ACL reconstruction was the major contributing factor to Petitioner's current diagnosis. Dr. Li felt no additional treatment, testing or surgery was necessary due to discrepancies between what the doctor saw on video surveillance and Petitioner's reported capabilities. He felt Petitioner could return to work as he had reached maximum medical improvement as of July 14, 2015. (RX2).

Following the exam, Respondent denied the right knee replacement surgery recommended by Dr. Watson based upon Dr. Li's opinion that Petitioner was at maximum medical improvement. (PX3, p. 20)

Petitioner returned to work for Respondent on August 13, 2015. (AX 1)

Petitioner was under video surveillance on August 17 and 20, 2015. On the 17th Petitioner was seen walking in a normal, fluid manner and using no assistive devices. On the 20th he was shown mowing his lawn with a zero turn mower, backing it into a trailer, stepping down from the trailer, securing the mower to the trailer, walking and bending, driving his truck and trailer to Sloan Farms. He used no assistive devices when walking. (RX 5, 7)

On September 2, 2015 Petitioner left a voice mail with Dr. Watson's office asking for the doctor to call. Dr. Watson did so that morning but no one answered and voicemail was unavailable. (PX 3, p. 3/107)

On September 16, 2015 video surveillance shows Petitioner driving his truck, walking, and working on a vehicle under the hood and putting air in the tires. He was also seen driving a combine. Petitioner was walking without the use of any assistive devices. (RX 6,7)

Dr. Michael Watson was deposed on December 16, 2015. (PX 7) Dr. Watson testified that he is board certified in orthopedic surgery and devotes 60% of his practice to lower extremities. Dr. Watson testified that he had previously treated Petitioner in 1997 for an ACL reconstruction and that Petitioner denied any further problems or symptoms until his recent work accident in 2015. When he initially met Petitioner in April of 2015 Petitioner was still working albeit with pain. Dr. Watson further testified that when he saw Petitioner on April 13, 2015, he performed standing AP and lateral x-rays of the knee. They showed moderately severe degenerative changes in the medial joint line with some bone spurs and osteoarthritis in the medial joint. Petitioner was noted to have an antalgic gait. Dr. Watson diagnosed Petitioner with osteoarthritis, a loosened anterior cruciate ligament, and medial and lateral meniscus tears. (PX7, pp. 12-14) Dr. Watson testified that Petitioner's ACL laxity was not likely due to Petitioner's injury. He also testified that the medial and lateral meniscus tears may or may not have been from the injury at work. He felt Petitioner's osteoarthritis was pre-existing but the work injury had aggravated it or more made the symptoms more severe. (PX7, p. 14)

Dr. Watson testified that during the arthroscopy, he observed chondromalacia, which is cartilage damage on the end of the bone, also known as arthritic changes. Dr. Watson graded the chondromalacia as Grade 3 out of a 4-grade scale. It was located on the medial femoral condyle and also the patellofemoral joint. Additionally, Petitioner had a complex tear of the medial meniscus and a tear of the lateral side. Dr. Watson performed a chondroplasty to address the chondromalacia and menisectomies for the tears. He noted the Grade 3 arthritis would be considered moderately severe. (PX7, pp. 16-18) Dr. Watson believed the work injury either accelerated or aggravated the chondromalacia to the point where it became symptomatic. The accident may have made the tears bigger, worse, and/or symptomatic but he was less certain. (PX7, pp. 18-20) Dr. Watson based his opinion regarding Petitioner's chondromalacia aggravation opinion on the fact Petitioner reported he had been working without symptoms, wasn't missing any work and wasn't having any specific trouble pre-accident. (PX 7, p. 20)

Dr. Watson testified that he took Petitioner off of therapy on June 9, 2015 because it was so painful for him. Dr. Watson testified that when he saw Petitioner on June 23, 2015, Petitioner's condition was worsening and he couldn't bear full weight. He also noted atrophy in Petitioner's right leg. Petitioner inquired about knee replacement surgery, noting he thought the surgery would help him get back to work. Dr. Watson testified that at the June 23, 2015 visit they discussed an option of knee replacement surgery. He agreed that 49 was young for a knee replacement but acknowledged performing

them on people in their late 30s explaining that as technology is changing it is becoming more and more possible to do so. He further testified that Petitioner's rationale for wanting to get his knee replaced had a lot to do with his ability to return back to work. They had discussed that on many occasions and he felt he was not going to be able to go back to work and would be limping around; however, if the knee replacement surgery could get him back to work they ought to just go ahead and do it now. Dr. Watson felt they should wait a little bit longer since Petitioner was only 5 ½ weeks post-op but Petitioner was fairly pessimistic. Dr. Watson also testified that Petitioner's other rationale had to do with workers' compensation and he felt that if something needed to be done he wanted it done as soon as possible so that he wouldn't be off work as long and so the insurance company/industry wouldn't cross over to the point where maybe it was due to something other than work. Dr. Watson also testified that he knew the insurance company wouldn't authorize the surgery right away and that litigation might be involved. (PX 7, pp. 23-25)

Dr. Watson also testified that in determining whether to recommend total knee replacement surgery for a patient, he looks at the patient's age, the patient's desire, whether the patient is symptomatic, pathological changes, and the ability to function. (PX7, pp. 22-29, 54) He explained that a total knee replacement is intended to be done because of osteoarthritis. Petitioner's x-rays and arthroscopic findings confirmed that he has osteoarthritis. Dr. Watson stated Petitioner was going to likely need a knee replacement at some point, but the injury caused him to need it now. He further testified that when he last saw Petitioner on August 5, 2015, he recommended a series of Hyalgan injections because the total knee replacement was denied by work comp, but the injections were denied as well. When asked if he was still recommending the Hyalgan injections and the total knee replacement, Dr. Watson replied that if they went with the injections they would go through the series and if he got some relief they would hold off on any discussion of knee replacement surgery. However, he noted the symptoms would return again because the injections are not a cure. (PX7, pp. 22-29)

On cross-examination, Dr. Watson noted that he performed an ACL ligament reconstruction on Petitioner's right knee in 1997. The x-rays Dr. Watson taken on April 13, 2015 showed pre-existing moderately severe degenerative changes, which would have been present prior to the Mach 12, 2015 work accident. The osteophytes shown on Petitioner's MRI also would have been present prior to the work accident. Dr. Watson testified that individuals with ACL reconstructions have a higher chance of developing osteoarthritis than those who don't undergo an ACL. Dr. Watson also agreed that regardless of the March 9, 2015 accident Petitioner would more likely than not need a total knee replacement in the future. He also reiterated that he didn't know the cause of Petitioner's meniscus tears. He also explained that he saw chondromalacia (a/k/a arthritis) during the surgery and some of it pre-existed the injury and it was significant. "Whether or not there was more of it following the injury, no one will know." Dr. Watson also noted Petitioner was experiencing pain post-surgery in the area of his meniscus and where the majority of his arthritis was located. (PX 7)

Dr. Watson testified that on June 23, 2015, Petitioner did not necessarily ask for a total knee replacement. Rather, the doctor brought it up and he asked to talk about it. Should Petitioner's condition improve, meaning his pain level becomes less and he is able to walk better, Dr. Watson would cancel the total knee replacement procedure. (PX7, pp. 31-43)

On cross-examination, Dr. Watson noted that it was his understanding that Petitioner was unable to walk without crutches except for very short distances. He understood Petitioner could walk on an uneven surface or in a cornfield, but that he did so with pain. Sitting on a tractor all day on a farm would not necessarily show Petitioner's condition had improved. If Petitioner was able to work prior to August 5, 2015 without crutches, whether that would change Dr. Watson's opinions would just depend on how much walking was involved. (PX7, pp. 44-48) Dr. Watson was posed a hypothetical in which he was asked to assume Petitioner was able to pull a flatbed trailer with a truck hauling a zero turn mower and

then use that mower to mow a lawn. He was told Petitioner was able to walk across the yard without crutches and step up and down from the trailer when securing the mower. He was sure that a person with a bad knee could still use a riding lawn mower and walking without a limp is not the standard for knee replacement surgery because a person can walk without a limp but still be in pain. (PX7, p. 49-52) Dr. Watson agreed that the more activity Petitioner is doing, the less likely he would need a knee replacement. (PX7, p. 54) With regard to the doctor's criteria for a total knee replacement, the doctor acknowledged that he did not know what Petitioner's current functional ability was, he did know his age, and he didn't know Petitioner's desire for surgery since August 5, 2015. (PX 7, pp. 54-55) He also reiterated that Petitioner's osteoarthritis was one of the criteria for the total knee replacement, that it clearly pre-existed the accident, and that the accident could have aggravated the condition. When asked if the aggravation could have been a temporary one, he explained that such a question involved a "tricky use of words" adding "The aggravation is based upon his subjective complaints. It's not his objective findings on x-rays or the scope. ...But if it's temporary, that means it made it worse and then it got better. If he got better, then it was temporary. So but as I sit here, I haven't seen him in five months. I don't know whether he got better or not." If he did get better there would no longer be a need for surgery as it related to his work accident. (PX 7, pp. 55-56)

On re-direct examination, Dr. Watson testified that Petitioner was asymptomatic prior to the work accident, and the accident could have rendered him symptomatic. Although the need for a total knee replacement is due to the osteoarthritis, the work injury made the condition worse to the point where it sped up the need for a total knee replacement. Dr. Watson based his opinion on his understanding that Petitioner was asymptomatic prior to the accident and experienced significant pain after the accident – not just a little bit. The doctor noted Petitioner continued to have severe pain the times he saw him so it's based upon his subjective complaints. Petitioner did have objective evidence of atrophy on June 23, 2015 and a positive Lachman's test. (PX7, pp. 56-58)

On further cross-examination Dr. Watson again agreed that the accident aggravated or caused the arthritis in Petitioner's knee to become symptomatic. He also agreed that it could have been temporarily aggravated. Having not seen Petitioner since August 5, 2015 Dr. Watson could not really provide an opinion regarding whether or not Petitioner still needs surgery. (PX 7, p. 60)

On final redirect examination Dr. Watson testified that he believed Petitioner was denied any further treatment (injections or surgery) as of August 5, 2015. (PX 7, pp. 60-61) He also acknowledged that Petitioner was supposed to return one month after the August 5th appointment but didn't. (PX 7, p. 62)

Dr. Li testified by evidence deposition taken on July 25, 2016. (RX 1) Dr. Li testified that he is board certified in orthopedic surgery. He also testified that he saw Petitioner on July 20, 2015. As part of the exam Dr. Li reviewed Petitioner's MRI report (not the film) and noted that there was extensive tearing of the medial meniscus and tri-compartmental osteophytosis and arthritis. He could not read the entire "Impression" section of the report because a post-it covered it; however, he believed it indicated extensive complex tearing of the medial meniscuses likely as a result of osteoarthritis and extensive cartilage loss in the medial joint line. Dr. Li explained that tri-compartmental osteoarthritis refers to bone spurring in all three compartments which is caused by osteoarthritis. Dr. Li further testified that Petitioner's osteoarthritis pre-dated his 2015 accident. He also testified that having had a previous ACL reconstruction surgery, such as Petitioner did, would have increased his risk of developing osteoarthritis.

Dr. Li testified that he performed a physical examination of Petitioner which showed his range of motion was slightly less than normal - from 5 to 110, whereas normal would be 0 to 120. His Lachman's was stable and his ACL was fine. He acknowledged that any attempt at McMurray testing (which involved the examiner twisting the knee and rotating the leg) caused severe pain and, therefore, the test

was not performed and Dr. Li attributed no clinical significance to the test. He did not detect any atrophy. Petitioner's x-rays showed severe osteoarthritis. (RX1, pp. 5-14)

Dr. Li opined the twisting injury Petitioner sustained at work aggravated his pre-existing osteoarthritis and degenerative meniscal tears in the right knee. His diagnosis as of July 20, 2015 was osteoarthritis because Petitioner's meniscal tears had been treated. The work accident caused an aggravation of Petitioner's meniscal tear that required arthroscopic surgery to address it, but Dr. Li did not believe it contributed at all to the osteoarthritis because that takes decades to form and would not have been accelerated by this type of a simple twisting injury. He found no evidence in the operative report that the injury caused any cartilage loss in Petitioner's knee.

Dr. Li believed the treatment to date has been reasonable and necessary. He did not believe Petitioner needed any additional treatment because Petitioner has pre-existing osteoarthritis and any symptoms would be coming from that. He had reviewed a surveillance video that was, in his opinion, inconsistent with what Petitioner had told Dr. Li he was capable of doing. Dr. Li testified that Petitioner is at maximum medical improvement and does not require work restrictions. (RX1, pp. 14-17)

Dr. Li believed that Petitioner might need a total knee replacement in the future, but that would likely be caused by the ACL reconstruction in 1997 because that is when Petitioner started developing severe osteoarthritis. Dr. Li acknowledged only seeing Petitioner once. He testified that if Petitioner is mowing lawns, walking across uneven surfaces and climbing on tractor trailers, it would be unlikely he would knee a knee replacement. Dr. Li further testified that Petitioner told him that he had to use crutches when there was any type of uneven ground and for walking longer distances. (RX1, pp. 17-20)

On cross-examination, Dr. Li acknowledged that he had no reason to disagree with the portion of Dr. Watson's notes which indicated Petitioner had an excellent outcome from his 1997 ACL reconstruction and was asymptomatic until the 2015 work accident. He further acknowledged that his report did not contain a specific section about surveillance and he could not recall what surveillance he reviewed, its length of time, or for how many days it covered. He agreed that Petitioner's pre-surgical symptoms and complaints were consistent with Dr. Watson's intra-operative findings of medial and lateral meniscal tears and grade 3 chondromalacia of the medial femoral condyle and patellofemoral joint. Dr. Li also testified that the discrepancy he referenced in his report was that Petitioner told him he was unable to walk long distances or on uneven ground without crutches but the video showed him walking on an uneven ground and longer distances. He felt the discrepancies called into question Petitioner's honesty. He acknowledged he didn't discuss the surveillance with Petitioner. However, he acknowledged Petitioner had bone on bone osteoarthritis documented on the x-rays. He further agreed that the findings of the x-rays and arthroscopy of bone on bone and grade 3 chondromalacia could be consistent with Petitioner's complaints of knee pain and tenderness over the medial femoral condyle post 2015 surgery. (RX1, pp. 23-33)

Dr. Li felt Petitioner sustained a temporary aggravation of his knee condition overall. The issue that was treated was the meniscal tears as osteoarthritis cannot be treated. He felt the meniscal tears were really what was causing Petitioner's symptoms. Dr. Li went on to explain that once the meniscus was repaired and no longer torn and "after a reasonable amount of therapy" the knee should be returned to what it was structurally. The doctor acknowledged that when he saw Petitioner he was still under Dr. Watson's care.

Dr. Li agreed that Petitioner's subjective symptoms continued after the 2015 surgery and that arthroscopies don't' treat arthritis. The arthroscopy was intended to address the tears while a TKR would address the osteoarthritis.

Dr. Li testified that 85-90% of his examinations are for employers.

On redirect examination Dr. Li testified that Petitioner's entire knee was temporarily aggravated by the work accident but not the arthritis. He explained that if there is bone on bone arthritis there could be no acute cartilage loss at the time of the accident. Dr. Li agreed, however, that swelling can be associated with osteoarthritis. (RX 1, pp. 34-39)

Petitioner's case proceeded to arbitration on a 19(b) basis on August 19, 2016. The disputed issues were causal connection, medical bills, and prospective care. Petitioner was the sole witness testifying at the hearing.

At the time of the hearing Petitioner was 50 years old. He had worked for Respondent five years performing new construction and maintenance on elevators. He travels from Effingham to Decatur and Jacksonville to Quincy in the course of his work. Petitioner testified that in 1997, he underwent an ACL reconstruction surgery with Dr. Michael Watson. Following his release from Dr. Watson's care about one year after surgery, he got along fine with his right knee. Prior to March 12, 2015, Petitioner did not undergo any form of treatment for his right knee and was able to perform the same type of work he currently does with elevators. He testified he felt fine, good, and returned to elevator work although he was working for a different company that was subsequently purchased by Respondent. He underwent no therapy for his knee between the time Dr. Watson released him after the 1997 accident (for which he treated about a year) and his accident herein. No doctor had recommended any injections or right knee surgeries in the interim and Petitioner denied undergoing or being told to undergo an MRI, x-ray or other diagnostic test for his right knee.

Petitioner testified that following the accident on March 12, 2015, Respondent referred him to Midwest Occupational Health Associates (MOHA). At that time he was noticing swelling and a lot of pain located on the inside part and outside part of his knee.

Petitioner testified that prior to the arthroscopy Dr. Watson cautioned Petitioner that, at some point, he would require a total knee replacement. Petitioner further testified the arthroscopy did not provide any relief. He testified that he tried to participate in physical therapy but during the second visit everything the therapist attempted to do created a lot of pain so the therapist stopped and wanted Dr. Watson to re-examine him. Thereafter, Dr. Watson suspended physical therapy. Petitioner testified that he tried to keep up with his home exercises during that time. He then saw Dr. Watson on June 23, 2015 and the doctor recommended he proceed with a total knee replacement.

Petitioner testified that the replacement procedure was not authorized by workers' compensation and he underwent an independent medical examination with Dr. Li on July 20, 2013. Petitioner testified that he spent less than ten minutes with Dr. Li and he looked at some x-rays, moved his knee in a couple of directions and asked Petitioner some questions.

Petitioner testified regarding the surveillance videos that Respondent conducted on him. Petitioner testified that he was unaware he was under surveillance. He noted that on June 28, 2015, he drove his wife, a photographer, to the Botanical Gardens at Washington Park in Springfield, Illinois because she was doing a photo shoot. He drove his Dodge Ram pick-up truck. The drive took about 15 or 20 minutes. He was at Botanical Gardens less than one hour. He did not walk the whole time as sometimes he just stood there. He carried a backpack but it weighed less than 10 pounds. Petitioner acknowledged that at the time of the surveillance he was under sedentary work restrictions. At no time did he walk in excess of two hours on the 28th.

Petitioner also testified that, with respect to the July 14, 2015 surveillance video, he walked into a cornfield. He testified that he pulled up to the edge of the cornfield, got out of his truck, walked about one row into the cornfield and checked an ear of corn for mold. He walked a total of 5 to 10 feet from his truck into the cornfield. It took about 15 seconds to walk into the cornfield, check the corn, and walk back to his truck. He did not use crutches to do this.

Petitioner denied telling Dr. Li that any time he walked on an uneven surface, he had to use crutches. He testified that he told Dr. Li that if he walked a lot or on uneven surfaces, his knee felt better if he used crutches. He did not believe he told the doctor he was unable to do it without crutches.

Petitioner also acknowledged being seen on a video using a zero turn riding lawnmower. He was mowing his lawn riding on the mower and he testified that he never used a push mower or a weed eater. He also testified that Dr. Watson never told him he shouldn't use a riding lawn mower. Petitioner further testified that he would drive out to the family farm to get the lawn mower and to return it. He never walked for more than two hours on the day he mowed or lifted anything weighing over ten pounds.

Petitioner went on to explain that Sloan Farms is a family farm, which his son and mother own and run. He helps out by driving a truck or a tractor and things of that nature. None of the activities he performs on the farm require him to walk for a distance of two hours during a day. They own 100 acres and rent another 850 or 900 acres. It is a grain farm only, meaning there is no livestock. They plant corn and beans in the in spring and harvest those in fall.

Petitioner testified that while he is able to mow his yard and help on his family's farm, his right knee still hurts while doing those things. He testified that, currently, he experiences a sharp pain when he walks and a dull/aching and burning pain when he sits. Walking up stairs causes an increase in his pain. He notices pain in his knee at the end of the day. Squatting hurts his knee. He noted that it feels like it is bone on bone and that he can feel and hear grinding and clicking in the knee. He described the location of his sharp pains as on the medial inside and outside of his knee. He takes Advil daily for knee pain. Petitioner gets along fine with his left knee.

Petitioner testified that he would like to proceed with a total knee replacement with Dr. Watson. He is constantly in pain and it hurts more as time goes along. Petitioner testified that he has several working years ahead of him and he wants to get it repaired so he doesn't have to walk and work in pain.

On cross-examination, Petitioner acknowledged asking Dr. Watson about a knee replacement on June 23, 2015. He stated that Dr. Watson had told him that the arthroscopy might not work. He further noted on cross-examination that he would not dispute the records if they showed that on August 5, 2015, he told Dr. Watson that he could not ambulate without the use of crutches. He also testified that he wore a wrap around his right knee. Petitioner described the corn field as a flat field and not an uneven surface. He has walked in cornfields a few times other than the incident on surveillance. He also stated that he took off of work for a week and a half in October 2015 to help his son with the harvest. He drove a tractor which pulled a grain cart and also drove a grain truck which was an automatic. Petitioner acknowledged that he isn't currently taking any pain medication or receiving any physical therapy. He agreed that Dr. Watson isn't currently recommending any treatment and he hasn't seen the doctor since August 5, 2015.

Petitioner testified that he is currently working for Respondent on a full-time basis. Petitioner also acknowledged that none of the surveillance videos show him using crutches for ambulation and that during that time he was reporting to Dr. Watson that he needed crutches to ambulate.

On redirect examination, Petitioner testified that Dr. Watson was the one who first brought up a total knee replacement on April 13, 2015, which was before the arthroscopy Dr. Watson performed. He further testified that he did not tell Dr. Watson that he needed crutches to ambulate, but, rather, that he used crutches because his knee felt better when he used them. Petitioner testified that he is able to do activities, but he does them with pain.

On further cross-examination Petitioner testified that Dr. Watson didn't recommend a total knee replacement on June 23, 2015; rather, he had told Petitioner previously that he would probably need one but the arthroscopy was "the lesser of two evils" so he wanted to try it first. When asked if he had osteoarthritis of his knee, Petitioner replied that he assumed so as he couldn't remember everything that was discussed.

Petitioner's medical bills are contained in Petitioner's Exhibit No. 8, which reflects $200.00 of unpaid bills. (PX8) These unpaid bills were for pre-operative visit at Springfield Clinic on July 24, 2015. (PX10, p. 10)

Petitioner's Exhibit No. 9 is an U.S. Department of Labor Form OWCP-5c, which defines sedentary work as exerting up to 10 pounds of force occasionally or a negligible amount of force frequently to lift, carry, push, pull, or otherwise move objects. Sedentary work involves sitting most of the time, but it may involve walking or standing for brief periods of time. The walking and standing must only be occasionally. Occasionally is defined as activity/condition exists up to ½ of the time no more than 2 hours and 40 minutes out of an 8-hour work day. (PX9)

Respondent conducted surveillance of Petitioner. Respondent's Exhibit No. 7 is a DVD from surveillance performed on June 28, 2015, July 9, 2015, July 14, 2015, August 17, 2015, August 20, 2015, and September 16, 2015. Respondent's Exhibit Nos. 4-6 are three reports from the surveillance performed on Petitioner, and the reports are dated July 21, 2015, August 25, 2015, and September 23, 2015, respectively.

The Arbitrator concludes:

With respect to issue (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner's current condition of ill-being in his right knee is causally connected to his undisputed accident of March 12, 2015. This conclusion is based upon a chain of events and Petitioner's credible testimony.

Both sides agree that Petitioner had pre-existing osteoarthritic changes in his right knee before March 12, 2015. However, he did not undergo any treatment to his right knee after his 1997 ACL reconstruction with Dr. Watson and before his 2015 accident and his testimony that he could work full duty as an elevator mechanic, lost no time from work, and underwent no treatment to his knee before his work accident of 2015, was unrebutted. No evidence was presented showing that any doctor had recommended that Petitioner undergo a total knee replacement before the accident herein.

Both sides also agree that on March 12, 2015, Petitioner sustained an accidental injury that arose out of and in the course of his employment. (AX1) On that day, Petitioner stepped in the side of a hole which was cut on a roof, while he was carrying an extension ladder. He testified at trial his leg buckled and he fell. Afterwards, he noticed a sharp pain in his right knee. Petitioner continued to work and did not seek any medical treatment until co-workers, noting he was limping, said something to him.

Both expert doctors agree, generally, regarding the conditions caused or aggravated by Petitioner's work accident. They agree the accident aggravated meniscal tears and they agree the accident aggravated Petitioner's osteoarthritis. The only real difference, and the primary basis upon which Respondent denied the total knee replacement procedure, is that Dr. Li is of the opinion Petitioner's aggravation was temporary and that Petitioner reached maximum medical improvement as of July 14, 2015. In comparison, Dr. Watson, based upon his deposition testimony, is really not certain if the aggravation was temporary or not as he hasn't seen Petitioner since August 5, 2015. However, as of August 5, 2015 he didn't feel the aggravation was a temporary one as Petitioner's condition had not improved and he had objective findings warranting, in his opinion, a total knee replacement.

The Arbitrator did not find Dr. Li's opinion that Petitioner's right knee was at maximum medical improvement as of July 14, 2015 persuasive. One of the problems with Dr. Li's opinions is that they were based on a one-time examination. Petitioner was never sent back to him for a re-examination at any time prior to the 19(b) hearing. While the doctor felt Petitioner had reached maximum medical improvement as of July 14, 2015 and needed no further treatment, he based that opinion on surveillance he had purportedly been shown[2]. Dr. Li never spoke to Petitioner or discussed with him the contents of the video surveillance; however, the doctor took the very strong position that based upon what he saw on the video it was at complete odds with what Petitioner had told him – essentially, he didn't believe Petitioner. With respect to the surveillance video noted by Dr. Li, only three videos were taken before Dr. Li's July 20, 2015 exam. On June 28, 2015 Petitioner is seen driving to Springfield, walking and standing around a botanical garden carrying a backpack without the use of crutches, braces, supports or other orthopedic devices. (RX 7, RX 4) On July 9, 2015, the surveillance recorded Petitioner driving a Ford F150 pick-up truck. He was not observed walking. On July 14, 2015, Petitioner was recorded driving his pick-up truck, walking into and out of a Casey's General Store and subsequently parking along a cornfield and walking about one row into the cornfield. (RX4, RX7) Petitioner credibly testified that the distance he walked from his truck into the cornfield was about 10 feet and it took about 15 seconds to check the corn for mold and walk back to his truck. The Arbitrator has viewed this video. It does not show Petitioner walking from his truck into the cornfield because after he presumably parked the truck next to the corn, the view of the video is obscured by a hill in the roadway. By the time the investigator drove by the area where Petitioner had parked, he was already standing in the cornfield a very short distance from the red pick-up truck. The Arbitrator does not find, based upon her review of the surveillance videos, that there is necessarily a discrepancy in what Petitioner reported to Dr. Li that he was capable of doing and what is depicted in the video. For instance, while the cornfield depicted in the video was hilly, it is very difficult to ascertain whether the 10 feet or so area Petitioner walked from his truck into the cornfield was uneven. Furthermore, Petitioner testified he told Dr. Li he used crutches on uneven surfaces because it helped his knee pain. He did not claim he was absolutely unable to walk on a short uneven surface without crutches.

The Arbitrator also notes several other issues with Dr. Li's evaluation of Petitioner. First, he did not have an accurate understanding of Petitioner's treatment as he incorrectly stated Petitioner had been initially treated by his primary care physician, Dr. "Bowers" and it was he that ordered an MRI. Petitioner was treated by "Dr. Brower", a MOHA physician, to which Petitioner had been referred by Respondent. Dr. Brower was not Petitioner's primary care physician. Thus, Dr. Li was unaware that all of Petitioner's treatment has essentially been driven by Respondent.

Dr. Li also didn't review the actual MRI or ever have a full and complete copy of the report. He also failed to explain why he felt that, as of July 20, 2015, Petitioner had fully healed from his

[2] It is also concerning that Dr. Li, relying so heavy on surveillance video evidence, never identified which video he was relying upon in his report nor could he clearly identify it in his deposition.

meniscectomies. Petitioner was clearly not asymptomatic at the time of that examination as the doctor noted pain during the exam. Dr. Li simply didn't believe Petitioner's pain complaints were genuine, again relying on alleged "discrepancies" showing Petitioner's dishonesty. Dr. Li, in this Arbitrator's opinion, rushed to judgment concerning Petitioner's credibility and, in turn, a finding of maximum medical improvement, as he never really discussed the video surveillance with Petitioner. He acknowledged that Petitioner told him he only needed them for walking on uneven ground and walking long distances. In this Arbitrator's opinion, none of the videos portray Petitioner walking on obvious "uneven ground" or long distances. Additionally, Dr. Li did not even ask Petitioner what Petitioner considered "uneven ground" or "long distances" to be. Furthermore, Dr. Li did not address whether Petitioner's accident might have hastened the need for a total knee replacement. Also, while he found Petitioner's accident made his pre-existing arthritis and meniscal tears more symptomatic thereby leading to the need for surgery, Dr. Li never addressed whether Petitioner's arthroscopic procedure itself could account for Petitioner's ongoing symptoms.

In support of his causal connection opinion, Dr. Watson reasoned, in part, that Petitioner was asymptomatic prior to the work accident, which then rendered him symptomatic. (RX7, pp. 56-58) While it is undisputed that Petitioner underwent an ACL reconstruction in 1997, it is also uncontradicted that he was asymptomatic between his release from Dr. Watson's care following that procedure in 1997 and the work accident of March 12, 2015. There are no medical records or testimony documenting any problems Petitioner may have had with his right knee during this time period. After the March 12, 2015 work accident, the medical records of MOHA document that Petitioner experienced swelling and pain in his right knee. (PX1) Dr. Watson's physical examination on April 13, 2015 showed an antalgic gait, tenderness in the medial joint line, pain with valgus stress, positive Lachman's test, positive McMurray's test and moderate-sized effusion. (PX3, p. 14)

In determining whether there is a causal connection between the March 12, 2015 work accident and Petitioner's current condition of ill-being, it is probative that Petitioner's symptoms continually persisted following the accident and even after the arthroscopy. Dr. Watson has never placed Petitioner at maximum medical improvement. While Dr. Li characterized the aggravation as temporary in nature, the medical records document that, as of August 5, 2015, Petitioner's osteoarthritic condition was more than just temporary as his symptoms had not resolved or diminished. "Absence of proof of ill-being of an employee prior to the time of the injury, coupled with a change immediately following the injury continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury." *Burrell v. Industrial Comm'n*, 171 Ill.App.3d 723, 729, 525 N.E.2d 935, 940 (1st Dist. 1988); *See also International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63-64, 442 N.E.2d 908, 911 (1982). The problematic part of this case is determining whether Petitioner's condition in his right knee since August 5, 2015 is still causally related to his accident. Petitioner has not returned to the doctor since August 5, 2015 and he has resumed working for Respondent. In the end, even Dr. Watson had no opinion on that issue because he has not seen Petitioner since August 5, 2015. Thus, the Arbitrator must look to a chain of events and Petitioner's credibility in order to determine whether Petitioner's current condition of ill-being in his right knee is causally related to the work accident.

The Arbitrator found Petitioner to be a credible witness. Petitioner's explanations for his level of activity, without crutches, as shown on the video surveillance were believable. He was not exceeding his sedentary work restrictions and he was not misleading his doctor as to his level of activity or need to use crutches. In the end, both Dr. Watson and Petitioner provided testimony corroborating one another as to their understanding of Petitioner's situation. While Petitioner did not provide any explanation for why he never returned to physical therapy after his "therapy vacation" Dr. Watson did not seem concerned by it and at no time has Dr. Watson suggested that Petitioner was not being honest. Petitioner has had no further accidents since the undisputed work accident in March of 2015. Petitioner has never been released by Dr. Watson. He has not returned to see the doctor and has returned to full duty work for

Respondent but both are understandable given Respondent's position on the case, the denial of further treatment, and the time required to get the case ready for hearing (ie. depositions). Petitioner testified to ongoing pain in his right knee. No credible evidence was presented showing that Petitioner's knee has returned to its pre-accident/baseline condition. Thus, the Arbitrator cannot find that Petitioner reached maximum medical improvement as of July 14, 2015, August 5, 2015 or any other date prior to the 19(b) hearing. Accordingly, the Arbitrator finds ongoing causation through a chain of events and Petitioner's credible testimony.

With respect to issue (J), were the medical services that were provided to Petitioner reasonable and necessary and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Petitioner is awarded reasonable and necessary medical bills of $27,130.12 as set forth in PX 8. The parties agreed at arbitration that the bulk of these bills have been paid and that only $200.00 remains outstanding. Petitioner's medical bills listed in Petitioner's Exhibit No. 8 are to be paid consistent with the Medical Fee Schedule, as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical bills that have been paid by its group health insurer, and Respondent shall hold Petitioner harmless for 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 adopts her conclusions of law contained above and incorporates them herein by this reference. She also notes that Dr. Li testified that all services rendered to Petitioner had been necessary and reasonable.

With respect to issue (K), is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

Prospective medical care, in the form of a total knee replacement, is denied. However, Petitioner is awarded a follow-up visit with Dr. Watson.

While the Arbitrator has concluded that Petitioner's current condition of ill-being is causally related to Petitioner's accident of March 12, 2015 she is unable to award prospective medical care as requested by Petitioner. In so concluding she relies upon Dr. Watson's testimony which clearly indicates he is uncertain as to Petitioner's current condition as he hasn't seen him since August 5, 2015 and, therefore, does not know if Petitioner is any better or worse. As the doctor noted in his records and testified in his deposition, he recommended the total knee replacement based upon the complaints voiced to him by Petitioner on June 23, 2015. However, he noted that if Petitioner's complaints diminished or his condition improved, they would re-evaluate the necessity for the procedure. When UR denied the procedure, it was noted that one of the reasons for denial was that Petitioner had not tried injections. When Dr. Watson appealed the decision he reasonably voiced the opinion, based upon Petitioner's condition at that time, that if the total knee replacement procedure wasn't going to be authorized then he hoped injections would be. The injections were not approved. Whether Dr. Watson would still recommend the injections or knee replacement surgery is wholly speculative at this time as he hasn't seen Petitioner in quite some time.

The Arbitrator feels it is appropriate for Petitioner to be awarded a follow-up appointment/visit with Dr. Watson to determine his current symptoms, complaints, and conditions and whether any further treatment is warranted. Petitioner has been working full-time since mid-August of 2015 and perhaps his condition has improved and the symptoms and complaints he testified to at the time of arbitration go to permanency rather than the need for additional treatment.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alice M. Short,
Petitioner,

vs. No. 13 WC 3130

18IWCC0194

State Governor's Office of Management & Budget,
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 accident, 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.

Petitioner testified she worked as an administrative assistant for the Governor's Office of Management and Budget, preparing forms, typing and filing. In an average day, which varied from 7½ hours to 16 hours, she would spend half her time at her desk, and the other half, filing.

On 10/11/12, Petitioner fell down a stairway while exiting her building after a fire alarm sounded. She hit her head on a bannister and fell head first, unconscious, onto a landing. She was taken to the emergency room of Memorial Medical Center, with complaints of head and neck pain. Her discharge diagnosis was concussion and neck sprain. The week after her accident, Petitioner began treating with her primary care physician, Dr. Vasconcelles, to whom she complained of shoulder, neck and "whole back" pain shooting down her arms and legs. Although Petitioner claimed those symptoms began after her accident, Dr. Vasconcelles' October and November 2012 records do not corroborate those complaints.

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Petitioner underwent physical therapy and chiropractic treatment with Dr. Venturini which she claimed provided little relief. She saw a neurologist, Dr. Warach, who ordered MRI's and EMG/NCV testing. She saw a pain management doctor, Dr. Salvacion, who administered two lumbar epidural steroid injections which provided no relief.

Petitioner testified her severe headaches lasted six months. In September 2013, Petitioner returned to her job at Respondent, working light duty on a part-time basis for two weeks, then returning full-time. Petitioner denied that her supervisors accommodated her restrictions. Because Petitioner asserted that she could not keep up with her work due to pain, Dr. Vasconcelles took her off work and has not released her, since.

Seven months after her accident, Petitioner returned to her psychiatrist, Dr. Tabatabai, with whom she previously treated for depression and anxiety. Prior to her accident, Petitioner claimed to have missed no work due to depression and anxiety, but asserted those conditions became unmanageable, after.

In April 2014, Petitioner began working a new part-time job answering phones as a secretary for Parkway Church, where she worked until she was terminated in March 2015. In September 2015, she began another part-time job as a switchboard operator for St. John's Hospital ("HSHS"); she quit that job in May 2016 because of the stress of directing phone calls.

At arbitration, Petitioner testified she still experiences dizziness and has balance problems. She still experiences headaches on a monthly basis, especially when the barometric pressure changes. She currently does gardening and spends time with her grandchildren.

Jennifer Cavanaugh testified on behalf of Respondent that she was Petitioner's supervisor. In October 2012, Petitioner's duties did not usually require lifting over 10 lbs.; many people were available there to help Petitioner with lifting, if needed. There was never a problem if Petitioner needed to stretch or stand. Contrary to Petitioner's testimony, Petitioner was never asked to work 60-hour weeks after her accident and she never did. When Petitioner returned to her job in October 2013, she never complained of difficulty keeping up with her workload.

Layla McLean testified on behalf of Respondent that her duties there included managing information regarding workers' compensation claims. She had knowledge of Petitioner's September 2013 work restrictions from Dr. Vasconcelles, and all were accommodated. Petitioner was also told to let Respondent know if there was anything they could do for her such as breaks to sit or stand, or altering her work schedule to accommodate appointments. Ms. McLean sent Petitioner emails informing her that Respondent was willing to take any means necessary to get her back to work and help her as required. In response, Petitioner sent off work slips and an email stating that she would not be returning to work after October 23, 2013.

Mark Gifford testified on behalf of Respondent that he was Petitioner's supervisor at the Parkway Christian Church when she worked there as a secretary for almost one year following her accident, from April 30, 2014 to March 16, 2015. She was always able to complete her work and never expressed difficulty about completing her assigned tasks. She was terminated for not advancing in her position.

Peggy Henry testified as a rebuttal witness on behalf of Petitioner that she worked for Respondent as an administrative assistant/receptionist, and was a co-worker of Petitioner. On October 11, 2012, she witnessed Petitioner fall head first down a 14-step flight of concrete stairs, hitting her neck and the back of her head. Prior to her accident, Petitioner was working on cleaning and moving files and cabinets from an office. Although Petitioner had to lift items weighing between 17-20 lbs., Petitioner could determine how much she could lift and carry.

Petitioner's initial treating records from the emergency room of Memorial Medical Center were not offered into evidence. The first record in evidence was Dr. Vasconcelles' office note of October 19, 2012, showing Petitioner complained of severe right-sided headaches and short-term memory loss. Dr. Vasconcelles' diagnosis was concussion and acute post-traumatic headaches. Two weeks later, Petitioner's complained of dizziness and neck stiffness; Dr. Vasconcelles added "neck sprain" to her diagnoses. Although Petitioner reported no new symptoms to Dr. Vasconcelles on December 6, 2012, a week later Petitioner reported experiencing a new low back pain that was different than the low back soreness she had experienced right after her fall. By January 2013 Petitioner reported her neck was improving, but that her pain was aggravated by her 60-hour work weeks.

Neurologist Dr. Joseph Warach reported in January 2013 that Petitioner's NCV studies were fairly unremarkable and provided no electrophysiologic explanation for her cervical and upper extremity pain syndrome, which may have had a musculoskeletal basis. Following a second EMG/NCV of the lower extremities, which showed subacute bilateral L5 radiculopathies, he suggested Petitioner see a pain specialist.

As the months went by, Dr. Warach reported that Petitioner's lumbosacral pain with radiation had worsened, while her dizziness had dramatically improved. By February 2013, Dr. Warach reported her dizziness had completely resolved, and she could return to light duty work.

Dr. Salvacion's March 2013 records show Petitioner told him that her back and right lower extremity pain had been present since October 2012. Dr. Salvacion administered two lumbar injections which provided no long-lasting benefit, and diagnosed Petitioner with lumbar degenerative disk disease and lumbar radiculopathy.

On August 29, 2013, Dr. Vasconcelles wrote that Petitioner's back discomfort was the reason she could not work. In March 2014, Dr. Vasconcelles reported that Petitioner suffered from chronic pain syndrome and fatigue since her work accident from which she would never recover, and he believed she would not be able to return to her occupation.

Although Petitioner had been working part-time at Parkway Church since April 2014, she told Dr. Vasconcelles on June 5, 2014 that she had not been able to return to work and was not receiving any income. In September 2014, Petitioner told Dr. Vasconcelles she had not worked for more than 1 year, even though she had been working the prior four months at Parkway.

Petitioner also treated with orthopedic physician, Dr. Williams. In May 2013 he reported that her pain stemmed from multilevel lumbar and cervical degenerative changes. He recommended conservative treatment and limiting her use of narcotic medications. In November 2013, he documented Petitioner's reports that: she had recently been diagnosed with fibromyalgia; her employer was demanding she work 12-15 hours per day, and she was determined she could not go back to work. Dr. Williams recommended she return to activities as tolerated, use non-steroidal anti-inflammatories and limit her use of narcotics.

Partial records of Petitioner's psychiatrist, Dr. Tabatabai, were offered into evidence. They did not include five years of Petitioner's pre-accident records or the two most recent years of her treatment. On May 8, 2013, Dr. Tabatabai diagnosed Petitioner with severe recurrent major depression and anxiety disorder, though he placed no work restrictions on her at that time. Six months later, Petitioner told him she had been working 13-hour days and was applying for disability. Dr. Tabatabai opined that Petitioner was unable to be gainfully employed and met the criteria for disability status, based on her current symptoms and her past history of severe depressive illness since 2007. Dr. Tabatabai's October 2014 note stated Petitioner remained depressed, anxious and overwhelmed; she was still disabled and might require hospital or in-patient care. Dr. Tabatabai's records did not show he was aware that Petitioner was working.

On August 26, 2013, Petitioner was examined by Respondent's Section 12 doctor, Stephen Pineda. Following his exam, Dr. Pineda gave his opinion that Petitioner's neck sprain, chronic headaches and concussion-related problems appeared resolved, though she still complained of low back pain. He opined she was at maximum medical improvement for her work accident, and could return to her regular job with no restrictions. He recommended a functional capacity evaluation, which Petitioner declined to undergo.

On June 24, 2014, Petitioner underwent a Section 12 examination by Dr. Stephen Weiss. His report documented her complaints of pain on superficial palpation, the presence of pain behavior, and an inconsistent response to straight leg raising. He found those all to be positive Waddell signs consistent with symptomatic magnification. Dr. Weiss diagnosed Petitioner with: pre-existing cervical and lumbar degenerative disc disease; soft tissue cervical and lumbar sprains and possibly a temporary exacerbation of pre-existing lumbar degenerative disc disease. He found her exam to be objectively unremarkable, and that her work injury had resolved without any permanency. He opined that she had reached MMI in June 2013 and that all treatment after that was unrelated to her work injury. He performed an AMA Impairment rating, and found her impairment to be 0% for her resolved cervical strain and 0% for her lumbar strain.

Petitioner has not undergone any surgery since her accident. The consensus of her doctors was that she was not a surgical candidate.

The Arbitrator found the following conditions to be related to Petitioner's fall down the stairs: neck and low back sprains, post-concussion headaches, fibromyalgia/chronic pain syndrome, depression and anxiety. The Arbitrator awarded Petitioner permanent and total disability benefits under §8(f) of the Act, as well payment of all of the medical expenses contained in Petitioner's Exhibit 9, under §8(a) and §8.2 of the Act. The Arbitrator further awarded Petitioner 109-3/7 weeks of temporary total disability benefits for intermittent periods

between January 10, 2013 and October 24, 2016 under §8(b) of the Act, and 84 weeks of temporary partial disability benefits for intermittent dates between April 15, 2014 and May 28, 2016 under §8(a) of the Act. The Arbitrator found Petitioner to be a credible witness, and found the opinions of Drs. Vasconcelles and Tabatabai to be more persuasive than those of Drs. Pineda and Weiss, because the latter doctors had not reviewed all of Petitioner's records.

The Commission views the evidence differently than did the Arbitrator. First, it does not find Petitioner to be a credible witness, for myriad reasons. She gave varying accounts of when her low back pain began, telling Dr. Williams that it started right after her fall, but telling Dr. Venturini that it came on gradually. Contrary to those histories, Dr. Vasconcelles reported on December 13, 2012, that Petitioner complained of "new" low back pain that was different than the soreness she had experienced at the time of her accident.

Petitioner also testified at arbitration that she still experiences dizzy spells, although Dr. Warach's April 2013 records reported that her dizziness had completely resolved. Petitioner told Dr. Vasconcelles in January 2013 that she was working 60-hour weeks, but her time records show she never worked more than 37½ hours in any week from her accident date through January 8, 2013. Petitioner told Dr. Tabatabai that she had been working up to 13-hour days, when her timesheets show she never worked more than 7½ hours on any day after her accident.

During the nine-month period when Petitioner worked for Parkway Church, she hid that fact from Dr. Vasconcelles, telling her that she was not working and had no income. Petitioner also told Dr. Weiss in April 2014 that she had not worked since October 2013, which was not true. Dr. Weiss found Petitioner had positive Waddell's signs and exhibited pain behaviors.

Petitioner's testimony that Respondent did not accommodate her restrictions when she returned to work in September 2013 was contradicted by two Respondent witnesses – Jennifer Cavanaugh and Layla McLean – who testified that all her restrictions were accommodated.

While the Arbitrator discounted the opinions of Drs. Pineda and Weiss for not having reviewed all of Petitioner's records, the Commission notes the Arbitrator's own findings were based upon incomplete records. Petitioner did not offer into evidence the initial emergency room records of Memorial Medical Center, where she was treated shortly after her accident. Dr. Tabatabai's records in evidence were incomplete; they were missing years of Petitioner's treatment with that doctor, both before and after her accident. The Commission questions the reliability of Dr. Tabatabai's two-year old opinion when, since then, he has provided two years of treatment. Portions of Dr. Vasconcelles' records were heavily redacted, including Petitioner's histories, active problems and her medications, some of which she blamed for her symptoms.

The Commission finds Petitioner provided inconsistent, incomplete and inaccurate histories to her treating physicians. The Commission finds that Petitioner's injuries from her work accident included only: a concussion, post-concussive headaches, temporary short-term memory loss, dizziness, and neck and back sprains and strains, most of which resolved in six to ten months following her accident.

The Commission finds Petitioner has not proven she is permanently and totally disabled from work as a result of her work accident. In so finding, the Commission relies upon the August 26, 2013 opinion of Dr. Pineda that Petitioner's chronic headaches and neck pain had resolved and she was at MMI and able to work without restrictions. Those opinions were consistent with the opinion of Dr. Warach that Petitioner's dizziness had resolved, and the opinion of Dr. Williams in November 2013 that her neck pain was tolerable and controllable.

While the Arbitrator found Petitioner's low back symptoms were causally related to her accident because they materialized, "within a reasonable amount of time," the medical records in evidence do not support such conclusion. In none of Dr. Vasconcelles' October and November 2012 office notes were there any reports of low back pain or complaints. Not until December 13, 2012, did Dr. Vasconcelles report Petitioner's complaint of new back pain, which Petitioner herself described as different than the soreness she experienced after her accident. The Commission finds Petitioner's lumbar spine symptoms and complaints on and after December 13, 2012 to be a new condition, unrelated to her work accident. While Petitioner suffered lumbar strains and sprains from her work accident, the Commission finds those had resolved prior December 13, 2012.

The Commission finds that Petitioner misled Dr. Vasconcelles and Dr. Tabatabai regarding her physical ability to work, as well as her reasons for not wanting to. Because their opinions were not based upon accurate and complete information, the Commission finds them less persuasive.

The Commission finds Petitioner has not proven her depression and anxiety were causally related to or aggravated by her accident. She suffered from those conditions prior to her accident. Without reviewing Dr. Tabatabai's diagnoses and findings prior to Petitioner's accident, the Commission is unable to ascertain whether those conditions were aggravated or exacerbated by her work accident, and if so, to what extent. Without Dr. Tabatabai's more recent records, the Commission cannot state whether Petitioner's anxiety or depression still are still present, and if so, the current cause thereof.

The Commission also finds Petitioner has not proven that her chronic pain syndrome or fibromyalgia were causally related to her accident. As the record shows, Petitioner's head and cervical injuries from her accident had resolved prior to those diagnoses – which were made following Petitioner's new onset of lumbar symptoms on December 13, 2012.

The Commission finds Petitioner has proven she sustained, as a result of her accident: a concussion; post-concussion headaches; short term memory loss; dizziness; vertigo, and cervical and lumbar sprains and strains. The Commission finds Petitioner has suffered permanent partial disability of 40% loss of use of person-as-a-whole under §8(d)2, based upon the following factors enumerated in §8.1(b):

(i) *Reported Impairment:* Dr. Weiss was the only physician to provide an AMA Impairment rating: 0% for both Petitioner's cervical strain, and 0% for her lumbar strain. The Commission gives this factor moderate weight.

(ii) *Injured Employee's Occupation:* Petitioner's occupation was that of an administrative assistant. The Commission finds that Petitioner recovered from her work injuries to the point that she was able to, and did, return to work at that position. The Commission gives this factor moderate weight.

(iii) *Age of Employee at Time of Injury:* Petitioner was 53 years old at the time of her injury. The Commission gives this factor moderate weight.

(iv) *Employee's Future Earning Capacity:* Dr. Pineda found Petitioner able to work without restrictions at her prior job as of August 26, 2013. While Petitioner is not currently working, that was not proven to be the result of injuries from her October 11, 2012 work accident. The Commission gives this factor some weight.

(v) *Evidence of Disability Corroborated by Treating Medical Records:* Petitioner worked for 3 months following her accident before any physician authorized her off work. She returned to her usual position at Respondent almost one year after her accident. Though she worked at that position for only one month, she demonstrated her ability to be gainfully employed by working two part-time jobs, lasting 10 and 8 months. The Commission gives this factor moderate weight.

The Commission finds Petitioner entitled to temporary total disability benefits for a period of 36-4/7 weeks, from January 10, 2013 through September 22, 2013, pursuant to §8(b) of the Act. She returned part time to her prior position on September 23, 2013. Although Dr. Pineda released Petitioner to full duty work the month before, Dr. Vasconcelles still had her on restrictions which Respondent did not accommodate until then.

The Arbitrator awarded Petitioner all the reasonable and necessary medical expenses set forth in Petitioner's exhibit, PX9. The Commission, however, finds the treatment for all of Petitioner's lumbar spine issues on and after December 13, 2012 to be unrelated to Petitioner's work accident. The Commission also finds Petitioner's conditions of depression, anxiety, chronic pain syndrome and fibromyalgia to be unrelated to her accident. The Commission reverses the award of any medical expenses incurred for the treatment of those injuries which may have been awarded by the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified. Respondent shall pay Petitioner temporary total disability benefits of $456.92/week for 36-4/7 weeks, commencing January 10, 2013 through September 22, 2013, as provided by §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary partial disability benefits is vacated.

18IWCC0194

IT IS FURTHER ORDERED BY THE COMMISSION the award of permanent and total disability benefits of $485.80/week for life commencing October 25, 2016 as provided in §8(b) of the Act, with possible cost-of-living adjustments paid by the Rate Adjustment Fund as provided in §8(g) of the Act, is hereby vacated. Instead, Respondent shall pay to Petitioner the sum of $411.23 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries to Petitioner's head and spine caused the 40% disability to the person-as-a-whole.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that the clerical error in the Arbitration decision on page 1, paragraph 4, is corrected from, "October 15th, 2016," to read, "October 15, 2012."

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: MAR 30 2018

o-01/31/18
jdl/mcp
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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHORT, ALICE M
Employee/Petitioner

Case# **13WC003130**

STATE GOVERNOR'S OFFICE OF MANAGEMENT BUDGET
Employer/Respondent

18IWCC0194

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:

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

JAN 6 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Alice M. Short
Employee/Petitioner

v.

State Governor's Office of Management Budget
Employer/Respondent

Case # 13 WC 3130

Consolidated cases: N/A

18IWCC0194

An *Application for Adjustment 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 **October 24, 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 _____

18IWCC0194

FINDINGS

On **October 11, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,640.00**; the average weekly wage was **$685.38**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$16,320.51** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$16,320.51**.

Respondent is entitled to a general credit for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical expenses as set forth in PX 9, including reimbursements to Petitioner for co-pays and out-of-pocket expenses and prescriptions, subject to the Medical Fee Schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for all medical bills previously paid, including any paid by its group medical plan for which credit is allowed under Section 8(j) of the Act and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of **$303.33/week** for **48 weeks**, commencing **4/15/14** through **3/16/15**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of **$290.79/week** for **36 weeks**, commencing **9/20/15** through **5/28/16**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$456.92/week** for **109 3/7 weeks**, commencing **January 10, 2013 through September 22, 2013 (a period of 36 4/7 weeks)**, and again from **October 25, 2013 through April 14, 2014 (a period of 24 4/7 weeks)**, from **March 17, 2015 through September 19, 2015 (a period of 27 weeks)** and from **May 29, 2016 through October 24, 2016 (a period of 21 2/7 weeks)**, as provided in Section 8(b) of the Act. Respondent shall receive credit for any TTD benefits previously paid.

Respondent shall pay Petitioner permanent and total disability benefits of **$485.80/week for life**, commencing **10-25-16**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

18IWCC0194

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

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

December 22, 2016
Date

JAN 6 - 2017

Alice M. Short v. State Governors Office of Management Budget, 13 WC 3130

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner was employed by Respondent on October 11, 2012, and had been so employed as an administrative assistant II for the preceding 5 years. On that date, Petitioner fell while exiting the building after a fire alarm had sounded. She recalled missing a step and falling, hitting her head on the hand rail. Respondent does not dispute accident. (See AX 1, RX 4, RX 5)

Petitioner testified that she did not remember the actual fall, but she did remember ending up head first on the landing with her legs above on the stairs. She recalled being helped up. She did not want to go to the hospital by ambulance, and called her husband, who transported her to Memorial Medical Center.

Records from Memorial Medical Center's emergency room are not a part of the record. Radiology records from that visit reflect a history of the fall with a loss of consciousness, followed by complaints of headaches, and neck pain. CT scans of the head and neck were performed. The CT of the head was normal, while the CT of Petitioner's neck revealed multi-level degenerative changes in the cervical spine. (PX5)

Petitioner did not work on October 12th or October 15th, 2016. She did work on October 17th and 18th, 2012. (RX 6)

Petitioner followed with her primary care physician, Dr. Vasconcelles, on October 19, 2012. At that time she complained of headaches but noted they were different from her longstanding migraines. There was no mention of neck pain or of a CT of the neck having been performed. A cursory/superficial examination of Petitioner's neck was performed and described as "normal." No examination of Petitioner's neck or back musculoskeletal structures appears to have been done. Dr. Vasconcelles' diagnosis was a concussion and acute post-traumatic headaches. Narcotic pain medication was prescribed. (PX1)

Petitioner continued working for Respondent on a full duty basis (7.5 hours/day) commencing October 24, 2012. (RX 6)

Petitioner returned to see Dr. Vasconcelles on November 5, 2012 four weeks after having "hit her head and also [straining] her neck and upper back." At that time Petitioner's chief complaint was neck and back pain, as well as continued headaches which were described as intermittent but no longer as frequent. Petitioner reported that her back and upper neck pain was getting worse, and occasional radicular tingling in the left upper extremity was reported. Dr. Vasconcelles performed a musculoskeletal inspection/palpation of Petitioner's joints, bones, and muscles which was provocative for pain and tightness to palpation in the posterior upper neck and back muscles bilaterally. Petitioner's diagnosis/assessment was: 1) concussion; 2) acute post-traumatic headaches; and 3) neck sprain. Dr. Vasconcelles added Gabapentin to Petitioner's medications, and physical therapy was ordered. (PX1)

Petitioner was seen at Memorial Industrial Rehabilitation on November 12, 2012, complaining at that time of neck, bilateral shoulder, and upper-mid back pain. Petitioner was working full duty and reporting headaches 2-3 times/week. Her complaints included intermittent left upper extremity tingling which was being experienced daily. Her pain was reported to have increased over the preceding 48 hours with activity, including prolonged sitting, neck rotation, driving, and reaching across her body. Petitioner's pain level was reported as 7 out 10 at its best. Physical examination noted decreased range of motion with pain in all planes of movement, and tenderness was noted throughout the neck and upper back (shoulder and scapula muscle groups). The therapist noted Petitioner's exam and findings were consistent with a neck sprain. (PX1, 3)

Petitioner attended physical therapy on November 29, 2012 reporting increased neck soreness/pain since the day before. She had walked to the next building at work (the capitol) and up some stairs and to several rooms all over the building noting increased soreness as she did so. A headache occurred shortly thereafter. (PX 1, 3)

Petitioner again attended therapy on December 5, 2012 reporting "2/10" pain in her neck and that she had been feeling better but still having some stiffness in her neck although it was greatly improved. (PX 1, 3)

Petitioner returned to Dr. Vasconcelles on December 6, 2012 for her "one month follow-up on neck and back pain." She made no specific low back complaints. On examination, she was noted to have palpable pain and muscle spasms in her upper back, left shoulder, and posterior back. Petitioner's diagnosis and assessment was unchanged. (PX1)

Petitioner worked 2.5 hours on December 13, 2012. (RX 6)

Petitioner again attended therapy on December 13, 2012 reporting that she had a worsening headache; however, her shoulders weren't too bad. Petitioner reported trouble sleeping and being worn out during the day. She also mentioned some low back and right hip soreness. No treatment appears to have been directed to those areas of complaints. Petitioner complained of some head pain and nausea with certain exercises. Therapy was placed on hold pending Petitioner's doctor's recommendations. (PX 1, 3)

On Petitioner's visit with Dr. Vasconcelles later that same day, Petitioner reported ongoing headaches but having trouble with physical therapy as the exercises "hurt her head." Petitioner had gone to therapy that morning but was unable to finish. Petitioner also reported a lot of pain in her low back and tailbone, as well as radiating pain down her right leg. Dr. Vasconcelles noted that "the low back pain was new," though Petitioner had reported low back soreness after the fall but "this was different." On examination, Petitioner had low back discomfort over her L5 musculature. Low back pain was added to the diagnosis. Petitioner was referred to a chiropractor. (PX1)

Petitioner cancelled her therapy appointment for December 14, 2012 advising the therapist that she had seen her doctor again and was going to try chiropractic care instead. (PX 3)

Petitioner did not work December 13, 2012 through December 26, 2012. (RX 6)

Petitioner presented to Dr. Venturini, a chiropractor, on December 17, 2012. Petitioner gave a history of going down a flight of stairs in response to a fire drill when she hit her head on the first stair which, she believed, caused her to become unconscious. Petitioner reported that, according to observers, she continued to fall down fourteen stairs hitting her head several times during the fall. She came to a stop, regained consciousness and continued out of the building. Her husband, thereafter, took her to Memorial Medical Center where CT scans were taken, "she was told she had fractures," and she was released. She then followed up with Dr. Vasconcelles who diagnosed her with a neck sprain. Petitioner further reported worsening headaches since December 1st. She had tried one trial of therapy but it had not helped her symptoms. She had tried another round this past week but had to stop when she became nauseous during the first session. Petitioner further reported missing work due to her symptoms. She was taking muscle relaxers that made her feel fired and "out of it." A secondary complaint included anterior forearm pain since the accident. She further reported the inability to work due to pain and weakness as she had been having problems with typing, standing, walking, stooping, squatting, kneeling, bending, carrying, lifting, reaching, sitting, nervousness and irritability. As a result of the accident Petitioner felt she was having difficulty going to sleep and would wake up in the middle of the night due to pain. She denied any problems with sleep prior to the accident. (PX 5) Petitioner's complaints that day included headaches, neck pain and low back pain, the latter two of which came on gradually after the accident. Petitioner's past medical history included headaches and anxiety. On examination the doctor noted tenderness in the cervical, thoracic and lumbar spine with reduced ranges of motion in the cervical and lumbar spines. Treatment to be undertaken was to include manipulation of the neck, low back, and mid-back. (PX5)

On follow-up visits with Dr. Venturini, continued complaints of headaches, low back pain, and left shoulder pain were made by Petitioner, as well as some complaints of dizziness. Petitioner completed a Neck Disability Index showing fairly severe pain with activities of daily living. Petitioner reported having felt better on Monday but after lying down for 45 minutes her pain was 3-4 times worse when she awakened. Dr. Vasconcelles wanted her off the Vicodin and changed her other medications but Petitioner couldn't "function like this" so she wasn't going into work. (PX 5)

Petitioner underwent chiropractic treatment on December 21, 2012 noting she was not as stiff when she woke up but was having problems with medication side effects. (PX 5)

As of December 26, 2012 Dr. Curtis (Dr. Venturini's office) was noting Petitioner's symptoms included left arm pain, low back pain, left shoulder blade pain, dizziness, left forearm pain, and right forearm pain. (PX 5)

Petitioner returned to work full duty on December 27, 2012. (RX 6)

As of December 28, 2012 Petitioner was reporting that nothing seemed better. She had taken the entire preceding week off and thought it would help but it didn't as she noticed stiffness when resting and headaches when up and moving. Her subjective pain complaints remained unchanged. (PX 5)

By January 3, 2013 when seen by Dr. Venturini, Petitioner was reporting no further forearm pain but that her neck, dizziness, and headaches were about the same. Dr. Venturini suggested a referral to a neurologist because her complaints were not responding to treatment. (PX5)

Petitioner signed her Application for Adjustment of Claim herein on January 3, 2013. (AX 2) Petitioner worked for Respondent on January 8, 2013. (RX 6)

On January 10, 2013, Dr. Vasconcelles re-examined Petitioner. Petitioner's complaints included head and neck pain. She reported being unable to work on a consistent basis due to pain and had not worked one full week since her accident. Dr. Vasconcelles noted "She is working at the State and is working for 60 hrs./week which seems to aggravate her pain." Petitioner reported malaise, confusion, and dizziness but denied any limb weakness or difficulty walking. Petitioner reported pain with palpation in her upper shoulders and the base of her neck. She was given a note for work limiting her to 37 hours "instead of the 60 hours she is currently working." When she examined Petitioner at that visit, the doctor noted Petitioner was taking Neurontin for her pain control and was continuing to experience headaches that could be quite severe. She had seen Dr. Venturini six times for her neck and head pain and had been unable to work on a consistent basis due to her pain, having only worked one week since October. Petitioner had continued headaches and neck pain despite medication and treatment. Dr. Vasconcelles changed medications and referred Petitioner to a neurologist. A Health Status Form (unsigned) and dated the same date indicated Petitioner was unable to work until seen by a neurologist due to post-traumatic headaches and neck pain. (PX1)

Dr. Warach, a neurologist, saw Petitioner on January 14, 2013. Petitioner gave a history of the accident and described her complaints since then: constant severe aching pain, variable in intensity, on the left side of her head where she hit it; dizziness associated with severe headaches; persistent constant aching and sharp pain in the posterior cervical region with radiation into both shoulders; neck stiffness; pain in both forearms which had resolved with chiropractic treatment but had returned over preceding two days and was now intermittent aching pain; intermittent aching pain in the low back with radiation down the entire right leg; and persistent memory difficulties. (PX 1)

Dr. Warach's neurological examination showed tenderness on percussion over the posterior cervical and lumbosacral regions. Straight-leg raising was positive of the right at 1 degree, and on the left at 5 degrees elevation. Petitioner also demonstrated an astasia-abasia gait pattern with tandem ambulation but was able to tandem ambulate. Dr. Warach's impression was that of:1) non-focal neurological examination (except for gait pattern); 2) status post concussive head injury; 3) post-concussive headaches; 4) post-traumatic memory difficulty; 5) post-traumatic dizziness and imbalance; 6) post-traumatic cervical and upper extremity pain syndrome, rule out cervical radiculopathy; 7) post-traumatic lumbosacral and lower extremity pain, rule out lumbosacral radiculopathy; and 8) bilateral forearm pain. Dr. Warach ordered MRI scans of Petitioner's brain, neck, and back, as well as EEG and EMG studies. (PX1)

Petitioner's MRI of her brain was normal. (PX 5) The MRI of the cervical spine showed minimal multi-level degenerative changes with mild neural foraminal encroachment at C3-4. A mild disc bulge at C5-6 was also noted. (PX2)

Petitioner's MRI of the lumbar spine dated January 18, 2013 revealed multilevel degenerative changes:

> At L3-4, a broad-based disc bulge and facet joint hypertrophy and thickening of the ligamentum flavum. Mild right and left neural foraminal encroachment.
>
> At L4-5, a broad-based disc bulge, facet joint hypertrophy and thickening of the ligamentum flavum. Mild to moderate right and mild left neural foraminal encroachment.
>
> At L5-S1, broad based disc bulge, with facet joint hypertrophy and thickening of the ligamentum flavum. It was noted that these findings were in the setting of congenital short pedicles. (PX2)

Petitioner's EEG studies were normal.(PX 1)

Petitioner's EMG/nerve conduction studies were considered "fairly unremarkable" and normal for the upper extremities. Studies of the lower extremities performed on January 31, 2013 were positive for bilateral L5 radiculopathies. (PX2; PX 1)

In a letter to Dr. Vasconcelles dated January 31, 2013 Dr. Warach reported on the above imaging studies and noted that Petitioner had bulging discs at L3-L5. He brought up the possibility of a referral to a pain specialist. (PX 1)

In follow-up with Petitioner on February 14, 2013, Dr. Warach noted that Petitioner's cervical complaints were improving, as was her dizziness. Petitioner was reporting persistent intermittent post-traumatic dizziness and imbalance with true vertigo consistent with a probable labyrinthine concussive injury. She seemed 50 % better. Her post-traumatic posterior cervical neck pain with radiation down both arms was characterized by aching and sharp pain, variable in intensity and with occasional tingling of her entire left arm but 40% better. Petitioner's intermittent post-traumatic lumbosacral pain with radiation down her entire right leg was not improved at all. She had also been experiencing constant posterior thoracic region pain with achiness and sharp pain in the preceding week but she did not wish to undergo any neurologic testing in that area. However, the low back pain and radiculopathy were not improved. Petitioner had undergone six chiropractic sessions with no benefit whatsoever. Petitioner was scheduled to go on vacation in Florida the next week. She was using Tramadol and Gabapentin as needed and her mental status was noted to be stable, speech fluent, and her ability to carry on conversation just fine. Dr. Warach's diagnoses were post-traumatic probable labyrinthine concussive injury; post-traumatic cervical and upper extremity pain; and post-traumatic lumbosacral and lower extremity pain; thoracic region pain; and bilateral L5 radiculopathies. He recommended additional physical therapy, and prescribed Antivert for the dizziness. Petitioner reported her therapy at memorial was of no help but she was willing to try again. Petitioner reported she wasn't working and the

doctor advised her to avoid heavy lifting, strain, and other provocative activities and to avoid ladders and other potentially dangerous activities. (PX2)

On March 11, 2013 Dr. Warach re-examined Petitioner who was reporting that she was experiencing constant lumbosacral pain with radiation down her right leg which had worsened since their last visit but was now 20 % better. She was also reporting persistent intermittent posterior cervical neck pain with radiation into both arms which had plateaued at 40% improvement. Her dizziness and vertigo was 90% better. Petitioner reported that she did not undergo the physical therapy previously ordered as workers' compensation would not approve it. She was not interested in an orthopedic or neurosurgical consultation but was interested in being referred to a regional pain clinic or specialist for consideration of appropriate injections. Motor strength testing revealed 5/5 strength in all four extremities. Her diagnoses remained unchanged. Petitioner was to speak with Dr. Vasconcelles regarding a referral. No other changes in her treatment were noted. (PX 2)

On March 21, 2013, Petitioner presented to Dr. Vasconcelles with an antalgic gait and reports of pain when lying flat. She also reported seeing Dr. Warach who found "3 slipped discs in her lumbar spine." Petitioner reported that her neck pain was manageable; however, her lower back pain was increasing and progressing since the accident. Petitioner also reported that her headaches were better and less frequent. Dr. Vasconcelles also noted a history of Petitioner's fall with her initial injury being upper neck pain and post-traumatic headaches. She wrote that Petitioner was doing much better in that regard but was now having low back pain secondary "to disc herniations" at L3-L5. Petitioner was to be undergoing a course of injections for her lower back pain and until then she was to remain off work because it entailed activity that could worsen/aggravate her back. Dr. Vasconcelles recommended evaluation and treatment by a pain clinic. (PX1)

Petitioner was seen by Dr. Salvacion for a pain consultation on March 28, 2013. Petitioner reported head, low back, and neck injuries since falling down a flight of stairs. In particular she described having a lot of pain in her back extending down her legs which she described as throbbing, pounding, crushing, and itching. His physical examination showed a painful gait and that Petitioner favored the right leg when walking. He also noted limited lumbar range of motion in flexion and extension, normal sensation to lower extremities, positive straight-leg raising bilaterally, and tenderness to palpation to lumbar spine midline. His impression was lumbar degenerative disc disease and lumbar radiculopathy. He recommended a trial of epidural steroid injections. (PX 1, 4)

Petitioner underwent an injection at L5-S1on April 9, 2013. (PX 4)

Dr. Warach re-examined Petitioner on April 22, 2013. Petitioner reported persistent constant lumbosacral pain with radiation down her right leg which was plateaued at 20% better. Her neck pain and radiating arm pain had worsened since their last visit but was now 10% better. Petitioner's right leg was occasionally giving out but her dizziness had resolved. She denied any other neurological complaints. Petitioner denied any relief from her lumbar epidural injection. Petitioner also told the doctor that Dr. Vasconcelles had referred her to Dr. Joseph Williams for an orthopedic consultation but it was canceled because workers' compensation had not approved

it. Dr. Warach recommended she proceed with it on her personal insurance. Her diagnoses were that of bilateral L5 radiculopathies and post-traumatic cervical and lumbosacral pain syndromes with upper and lower extremity pain syndromes. Dr. Warach felt Petitioner could work in a light duty capacity. (PX 2)

Petitioner followed up with Dr. Vasconcelles on April 22, 2013, reporting no improvement following the first injection. Petitioner also reported that her right lower extremity had given out several times as "she has herniated discs" in her low back and that Dr. Warach had found worsening nerve damage in her back. A surgical consultation was discussed. Petitioner was kept off work for her low back pain and radiculopathy. (PX1; PX 2)

Petitioner underwent another injection but at L4-5 on April 25, 2013. (PX 4)

Upon the referral of Dr. Vasconcelles, Petitioner saw Dr. Williams, an orthopedic surgeon, on May 7, 2013 for complaints of chronic low back pain which Petitioner represented had been present since a fall down concrete steps at work on October 12, 2012. (PX 1, PX 6) He also noted complaints of axial neck pain and bilateral upper extremity pain, with the left being worse than the right. Petitioner told the doctor that she was an executive assistant in the Governor's Office and had worked from October through January as the pain was tolerable; however, since then she had been unable to do so. Dr. Williams reviewed the films and other studies and performed a physical examination, which did not reveal any focal deficits to her upper or lower extremities. He felt Petitioner had multilevel lumbar and cervical degenerative changes, "all of which are sources of pain." He did not feel surgery would provide the relief Petitioner was looking for, and, therefore, recommended further conservative care. He further recommended limiting her use of narcotic pain medication. (PX 6)

Petitioner presented to Dr. Tabatabai, a psychiatrist, on May 8, 2013, having last been seen in June of 2012. According to his notes Petitioner had fallen down stairs at work in October of 2012 and had been on short-term disability since "Jan. 2012." Her history included diagnoses of cervical and lumbar disc disease with two pain shots and increased anxiety, racing thoughts, insomnia, "etc." Petitioner reported trying to stay active at home but being limited by pain. She was doing physical therapy at home and spending time with her mother who was now fairly healthy. She was assessed with severe recurrent major depression and non-specific anxiety disorder. Medications were adjusted. (PX 7)

As of May 20, 2013 when Petitioner again saw Dr. Vasconcelles, the doctor was noting chronic neck pain due to Petitioner's "herniated disc" after a fall at work. The injections hadn't really helped. She was on Neurontin and tramadol but the latter wasn't as effective as Ibuprofen. Petitioner reported she still wasn't back to work due to her pain and limitations. Her job would reportedly require her to file, write/type and walk long distances and due to her level of discomfort she didn't feel that would be possible. Petitioner was performing stretching exercises she had learned on the Internet. Dr. Venturini was only addressing her lower back pain and she had stopped going to him due to appointments running out. Petitioner felt her lower back pain was better but her neck pain was now the problem. Petitioner also reported that she was having right lower extremity pain that would radiate down to her ankle and, sometimes with stairs, it

would feel like her leg was going to give out. Dr. Vasconcelles continued Petitioner's leave and sent her back to Dr. Venturini for her neck pain and possible use of a TENs unit. (PX 1)

Dr. Venturini re-examined Petitioner on June 19, 2013 noting she was there for persistent, continued lower back pain bilaterally, right buttock, hip, posterior lateral to lateral calf and heel which she felt were related to her fall at work. Petitioner reported that her low back pain, right buttock pain, right hamstring pain, right calf pain, and right heel pain came on gradually after the accident but was progressively worsening. Petitioner reported her neck pain was immediate after her work accident. With regard to her neck pain she noticed it in the morning but it would be aggravated in the afternoon. Petitioner's physical exam was positive for tenderness upon palpation and muscle tension. Some trigger points were noted. A Revised Oswestry Assessment was performed regarding Petitioner's low back pain. A Neck Disability Index was also completed. The former reflected a crippling disability while the latter was described as "severe." (PX 5)

Petitioner reported some improvement in her symptoms when seen by the chiropractor on June 21, 2013. (PX 5)

Petitioner denied any improvement when seen by Dr. Venturini on June 24, 2013 noting that she had helped hang some pictures with a friend and it really aggravated her back. She also reported some "extra stress" on Saturday with work comp issues. The focus of the exam was her low back as that was her primary area of complaint. (PX 5)

On June 24, 2013 Petitioner returned to see Dr. Vasconcelles in "follow up" for her upper back and neck after a fall. She continued to complain of lower back pain going into her right leg. She was seeing Dr. Venturini and Dr. Curtis and noting some improvement. Petitioner also reported bilateral ankle swelling but no pain. That had begun two weeks earlier. A prior history of similar complaints was noted. She was noted to be in no acute distress, well appearing, and appearing normal. Petitioner was described as appearing more comfortable and less stressed. On examination she had some pain, tenderness and tightness in her neck and upper shoulders. (PX 1)

Dr. Venturini noted "some improvement" when he examined Petitioner on July 3, 2013. (PX 5)

Dr. Peter Curtis conducted a re-evaluation of Petitioner on July 12, 2013 regarding her lower back and neck complaints with Petitioner reporting an exacerbation of lower back complaints over the 4th of July Holiday weekend. Petitioner felt unable to perform physical work activities and had ongoing problems with sleep. (PX 5)

Petitioner presented to Dr. Venturini's office on July 18, 2013 reporting no improvement since her last visit. (PX 5)

When examined by Dr. Vasconcelles on July 19, 2013 Petitioner reported undergoing therapy with Dr. Curtis and chiropractic care with Dr. Venturini. Petitioner wished to go back to work in mid-August although she mentioned a flare several weeks earlier which was probably due to stress as she had received a letter about an examination in St. Louis with a doctor chosen by her

employer. Petitioner reported that her attorney needed a letter with a restriction asking her to be examined by someone in Springfield as sitting in a car for more than ½ hour hurt her back. She denied any new symptoms and was taking Gabapentin daily and also using Ibuprofen but wished to switch to something less frequent. Petitioner was using her Vicodin sparingly. The doctor began her on Mobic instead of the Ibuprofen. (PX 1)

Petitioner's final visit with the chiropractor was on July 29, 2013 when she reported no improvement although she was able to do a "deep cleaning" at her house without a flare-up. She thought stress was aggravating her low back pain. (PX 5)

Petitioner returned to see Dr. Venturini on August 5, 2013, having last seen him in June of 2013. Petitioner reported a return of symptoms or increase of complaints since her last visit. She had been very busy the past Thursday and her energy level was pretty low. She was busy over the weekend as well and in the pool which felt good; however, when she emerged from it, her low back hurt. Petitioner also reported having some neck pain recently and she had been doing her physical therapy exercises previously taught to her. Petitioner's subjective pain complaints included low back pain, right buttock pain, right shoulder blade pain, neck pain and mid-back pain. (PX 5)

Petitioner continued to follow with Dr. Vasconcelles on August 15, 2013 reporting trouble sleeping due to pain and that she had been "hurting" for the last two weeks with no known triggers. Petitioner was seeing Dr. Venturini and undergoing some therapy with improvement. She was hoping to return to work on August 16th but didn't feel she could do so due to her pain. Petitioner was taking her Vicodin sparingly and had discontinued Mobic as it didn't help. She was also on Gabapentin which had helped initially but no longer. Petitioner reported some tension headaches. Petitioner's Vicodin was increased and her Gabapentin stopped. Petitioner remained off work until her pain improved. Her diagnoses remained unchanged. She was to return in two weeks. (PX 1)

At the request of Respondent, Petitioner was examined by Dr. Stephen Pineda on August 26, 2013. In his report he noted a separate medical summary not otherwise discussed or mentioned in his report. Petitioner reported her current medications were Cymbalta, Clonazepam, Lyrica (just begun a day or two earlier), aspirin, vitamins, and, on rare occasion, Hydrocodone for pain. Petitioner described her job as involving office work with the occasional need to assist in moving an office which might require her to move boxes or packages weighing up to fifty pounds. Petitioner described her injury and further acknowledged having continued to work from the date of accident through January of 2013. In his report, Dr. Pineda noted that Petitioner's initial headaches and neck strain had seemed to resolve; however, she continued with lower back pain and right leg problems which were doing better until mid-August when she was scheduled to go back to work, had a flare-up and her pain became so severe that she could not go back to work. Dr. Pineda agreed that Petitioner was not a surgical candidate. His diagnosis was lumbar pain with a history of degenerative disc disease. On the issue of causation, he stated, "the only statements that one can make regarding causality is that she states this pain began at the time of the fall." As for further treatment, Pineda opined, "The only reasonable strategy that I would recommend right now is symptom control." He suggested that from a mechanical standpoint, Petitioner did not need any activity restrictions. However, he noted that pain would be a

restrictor of activities. He noted no neurological deficits. Her physical exam was benign. He thought an FCE might be considered if an exact measurement of her true capabilities was required. (PX 8; RX1)

Petitioner returned to Dr. Vasconcelles on August 29, 2013. Dr. Vasconcelles noted that Petitioner has had "chronic back and neck pain since an injury at work about 10 months [earlier.]" Petitioner advised the doctor that she wanted to return to work but was concerned about her ability to do so given her chronic, persistent pain. Petitioner also reported that she had cancelled her second opinion with a chiropractor per the advice of Dr. Pineda. Dr. Vasconcelles thought Petitioner should remain off work for two weeks owing to a recent "flare-up of her pain" and see how she was doing in a couple of weeks. She also wanted Petitioner to follow-up with Dr. Salvacion regarding long-term management of her pain. Petitioner was to return on September 12, 2013 to determine her ability to return to work after discussing the matter of restrictions with her attorney. (PX1)

Petitioner saw Dr. Salvacion on September 9, 2013 for her back and right leg pain. She gave an interim history of no long-standing improvement with the epidural injections, and continued pain in the low back and into the right leg. She complained that the worst pain at that time was muscular across her low back with spasms in the lumbar region going up into the thoracic region. Petitioner noted she had been back to see Dr. Pineda and he thought, Dr. Williams, neither of whom had recommended surgery. On examination, Dr. Salvacion found spasms in the lumbar and thoracic paraspinal musculature. He recommended against further injections, but did prescribe a new medication (Blaclofen) for the spasms. He referred Petitioner to the Marianjoy Rehabilitation Institute in Wheaton for evaluation of the ongoing musculoskeletal pain and lumbar radiculopathy to try to improve Petitioner's functional ability and allow her to return to work. (PX 1, 4)

Dr. Vasconcelles re-examined Petitioner on September 12, 2013 with Petitioner reporting she had seen Dr. Salvacion for her chronic pain per the suggestion of her "Workman's comp staff at work." She wasn't back to work due to her pain and was having a particularly bad day that day. Petitioner reported low back pain radiating up her back and wondering if it could be her kidneys. She was told to return in one month and that her leave would be continued for one month until she decided on her next step for treatment. Petitioner remained off work due to chronic pain syndrome and back pain.(PX 1)

Based on Dr. Pineda's report, Respondent terminated Petitioner's TTD benefits and had her return to work. She was paid temporary total disability benefits through September 22, 2013. (RX3).

Petitioner saw Dr. Vasconcelles before her return to work, on September 23, 2013. The doctor noted Petitioner was an administrative assistant but had to back up the receptionist at times. Petitioner reported some improvement with her pain control. Dr. Vasconcelles signed off on the return to work, with restrictions of no lifting over 10 lbs., no pushing or pulling over 10 lbs. with her arms, no reaching above shoulder level and no standing over 10 minutes or sitting over 30 minutes without moving/stretching. These restrictions were to remain in effect until October 15,

2013. (PX 1) The doctor also commented that Petitioner would need time off (FMLA) for severe flare-ups of her pain. (PX1)

Petitioner returned to work on September 24, 2013 initially working half days and then proceeding, as of October 5, 2013 to full days. (RX 6)

Petitioner returned to see Dr. Vasconcelles on October 15, 2013. Petitioner had been back at work for four weeks although the first two weeks were only half days. She described it as rough, with continued pain and a lot of fatigue. Petitioner reported using a massage chair at home which helped. Dr. Vasconcelles allowed her to continue with work, but added that if Petitioner's responsibilities were increased to the point of it being a problem, restrictions would be revisited. (PX1)
Petitioner stopped working for Respondent as of October 23, 2013. (RX 6)

Petitioned returned to see Dr. Vasconcelles on October 25, 2013.She reported a flare-up of her chronic pain syndrome beginning the previous day. She had transitioned to full-time work, and had experienced pain and was very uncomfortable. Dr. Vasconcelles found soft tissue pain and trigger points on examination. She increased the Lyrica being prescribed, and wanted her to see Dr. Williams again. She also noted that Petitioner was going to apply for permanent disability due to the persistent and chronic nature of her symptoms. (PX1)

In a separate note from that visit, Dr. Vasconcelles wrote:

> [Petitioner] was in my office today and is having continued pain associated with her chronic pain syndrome so I have decided she is to again stop working and apply for permanent disability. The prognosis that she will recover full function without pain is poor, especially now that she has been suffering for over 1 year. The stress of performing her job is contributing to her persistent pain issues so removing her from the work environment so she can rest and pursue alternative treatments is necessary. (PX1)

In a note dated November 5, 2013 Petitioner left forms for Dr. Vasconcelles to complete regarding disability benefits for the period of January through September of 2013. Dr. Vasconcelles completed the Occupational Disability Report on November 8, 2013 indicating Petitioner was suffering from chronic pain syndrome/fibromyalgia and degenerative disc disease in her neck and back and was unable to work from January 5, 2013 through September 23, 2013. A second form gave an onset date of November 1, 2013. When she would be able to return to work was unknown as Petitioner was applying for permanent disability. (PX 1)

Petitioner returned to see Dr. Tabatabai on November 7, 2013 reporting that she had seen the workman's compensation doctor who had released her to work and she had done so on September 23, 2013. Her primary care doctor had given her restrictions two weeks ago "woke up and unable to move, had to use hydrocodone to be able to work" which required as much as 13 hours per day. She was now applying for permanent disability. She appeared tearful, low, and frustrated and "financial stress" was noted. Petitioner's medication was adjusted. Her diagnoses remained the same as in May of 2013. (PX 7)

Petitioner returned to see Dr. Williams on November 19, 2013 in regard to her low back. At that time she was still complaining of lower back pain and radiating right leg pain. She also noted tingling in her leg and random stabbing pains all over her back. Petitioner reported having returned to work on September 23, 2013 and then developing worsening pain which required her to take excessive amounts of Norco through the day to maintain her work. Petitioner stopped working on October 25, 2013. Petitioner's current medications included 2 Norco tablets, 75 mg. of Lyrica, and Cymbalta on a daily basis. Petitioner had quit smoking six months earlier. Petitioner reported being diagnosed with fibromyalgia earlier in the month and also reported the inability to sit or stand. She was noted to be tearful and stated that her employer and supervisor at work were demanding that she work 12 – 16 hours per day. Petitioner also reported neck pain but not as bad as her back pain. Dr. Williams again noted the MRI findings which did not suggest any nerve root impingement or instability and he saw no need for surgery. He recommended activities as tolerated and limiting her use of narcotics. She was to return as needed. (PX 1, 6)

Dr. Vasconcelles re-examined Petitioner on December 3, 2013 for her ongoing chronic pain syndrome. Petitioner reported good days and bad days with and without medication. She was experiencing some lightheadness with Lyrica. Petitioner was not working. She reported sharp, shooting pains in her neck and mid-back episodic in nature. Nothing reportedly helped with the pain but it would eventually resolve on its own. She also reported radiation down into her legs and her right arm. Dr. Vasconcelles noted that Petitioner had "known disc herniations" in the neck and lower back but the surgeons were of the opinion they were not surgical in nature and probably not causing her pain. Petitioner was diagnosed with chronic pain syndrome and fatigue. Dr. Vasconcelles noted in Petitioner's Health Status form that Petitioner was unable to work due to chronic pain syndrome. (PX 1)

On December 13, 2013 Respondent's attorney advised Petitioner's attorney an FCE was being scheduled. (RX 7)

In an email dated January 9, 2014 Linda O'Neall from CMS advised Respondent's attorney that Petitioner had advised she did not wish to go through the FCE because she didn't think it would help her. Furthermore, if one did end up being scheduled Petitioner wished to speak with her attorney first. (RX 7)

Petitioner followed up with Dr. Tabatabai on January 29, 2014. Petitioner reported being three months without any income as she had been denied state retirement. Petitioner appeared very depressed and anxious, did not want any more medication, was irritable with her husband, and wanted a letter, if possible, to assist her. She further noted that her attorney wouldn't call her back, she was going to be losing her insurance which cost $1600.00 per month, and she had an appeal scheduled for the following week regarding her retirement. Petitioner's physical limitations included back pain, the inability to sit for longer than 30 minutes, back pain when sitting, the inability to stand more than 10 minutes, and pain down her right leg with bending and lifting. Petitioner's emotional limitations included the inability to concentrate, crying, irritability, and hopelessness. Her diagnoses remained unchanged with the doctor noting that Petitioner had chronic pain syndrome which was limiting her activity level and contributing to her depressive symptoms. He did not feel she was able to be gainfully employed at that time. (PX 7)

In a letter addressed "To Whom It May Concern" and dated January 30, 2014, Dr. Tabatabai wrote that he had been following Petitioner for a number of years for her major depressive disorder and anxiety disorder having first seen her in 2007 as part of a partial hospital program at Memorial Medical Center. At that time Petitioner had fairly significant depressive symptoms but she improved with aggressive treatment and had always been compliant with care and treatment. With regard to her injury, Dr. Tabatabai noted that Petitioner had been off and on from work for a period of time after the accident but unable to return after October 23, 2013. Since then "she has had a pain syndrome as well as exacerbation of depressive illness." She was last seen in his office the day before and had fairly significant depressive symptoms at that time. He wrote, "Obviously this is a pre-existing diagnosis but exacerbated by chronic pain, financial stress, and the lengthy disability process." Dr. Tabatabai noted that Petitioner was continuing to have physical limitations with difficulty sitting or standing longer than ten to thirty minutes and was experiencing fairly constant low back pain with some radiation down the right leg. Additionally, she was quite emotionally labile/tearful with difficulty concentrating and retaining information. Her self-care had reportedly declined, she felt helpless and hopeless, and was experiencing a very restricted activity level at home. Dr. Tabatabai felt Petitioner, from a mental health perspective, was completely unable to manage a part-time or full-time job of any kind. He felt her pain syndrome had contributed to both her physical and emotional limitations. He felt she fit the criteria for disability status. His plan was to continue monitoring Petitioner in an effort to stabilize her depression and improve her quality of life and ability to function. (PX 7)

Petitioner returned to see Dr. Vasconcelles on March 4, 2014 for a three month follow up visit after "having had an accident at work one year earlier that had triggered a chronic pain syndrome." Petitioner also reported losing her health insurance, not currently receiving any compensation and having been turned down for FMLA. Petitioner reported ongoing pain for which she used Lyrica and tried stretching exercises. She had been seen in therapy and instructed in exercises for management. Petitioner reported persistent lower back pain and intermittent pain in her neck, left flank and mid-back. Petitioner reported strains in her marriage due to her health issues and she wasn't seeing a therapist. The need for a therapist to assist with Petitioner's chronic pain management was noted with the understanding that they would follow up on a referral when Petitioner had health insurance. The doctor authored a note stating that she had seen Petitioner that day for her chronic pain syndrome and fatigue post injury two years earlier. Dr. Vasconcelles described Petitioner's symptoms and daily pain as unchanged and she felt Petitioner was unable to work and was going to pursue her permanent disability status as it is "my opinion that she will never recover from this medical diagnosis and will not be able to return to her occupation." (PX 1)

Petitioner began working at Parkway Christian Church in April of 2014 as a secretary/office administrator. She was to perform general secretarial services at $11.50 an hour up to 20 hours per week. Under the terms of the agreement it was to end on December 31, 2014. (PX 11; RX 9)

Petitioner was examined by Dr. Vasconcelles on June 5, 2014 regarding her chronic pain syndrome and inability to return to work. Petitioner reported she was working with her disability attorney to get full disability but she wasn't receiving any income currently which was very stressful. Petitioner had cashed in her retirement for income and had been without any payments

for approximately 8 months. Petitioner reported flares of her pain due to stress and she was using her Vicodin sparingly for pain management but only when it was bad. Petitioner was trying to stay as active as possible doing her exercises at home noting that if she stayed active she felt better but sometimes she was so fatigued that she couldn't do her exercises. Petitioner was not seeing a therapist for her stress and her chronic pain because it would not be covered as she had lost her health insurance and all current care was with workers' compensation. In a note dated June 5, 2014 Dr. Vasconcelles stated she was Petitioner's primary care doctor and had seen her that day for her continued leave from work due to her chronic pain syndrome. Petitioner was noted to be having ongoing pain and fatigue and was unable to return to work. She was to be re-evaluated in three months. (PX 1)

At the request of Respondent, Petitioner was examined by Dr. Stephen Weiss on June 24, 2014. A written report followed. As part of the history noted by the doctor, Petitioner denied any prior problems with her neck or lower back. They reviewed her treatment after the accident and with Dr. Vasconcelles including her referrals to Dr. Warach, physical therapy and injections. Petitioner further reported being diagnosed with fibromyalgia in October of 2013 and being prescribed Lyrica for it. Dr. Weiss' report reflects no review of any medical records after March 4, 2014. He reviewed no records of Dr. Tabatabai or Dr. Williams. Dr. Weiss did review an October 11, 2012 emergency room note indicated Petitioner had a headache and right knee pain after falling down a flight of steps. X-rays of her right knee were negative. Additionally, according to the October 17, 2012 Employer's First Report of Injury, Petitioner was exiting the fire drill and slipped injuring her head, back, elbow, and right hip. (RX 2, p. 4)

At the time of her exam with Dr. Weiss, Petitioner's complaints included constant neck pain with intermittent radiation down both upper extremities to her wrists as well as constant low back pain with intermittent pain running down to her right foot. She had not worked since October of 2013. Dr. Weiss further noted in his report that Petitioner told him he was missing a referral from Dr. Pineda to a pain clinic which, in turn, referred her for physical therapy; however, she never underwent the therapy as workers' compensation would not approve it. Dr. Weiss noted some limitations in motion on examination of Petitioner's neck and low back, but his examination was otherwise unremarkable. Dr. Weiss noted Petitioner's Waddell's signs were positive, a suggestion to him of symptom magnification. He felt Petitioner was at maximum medical improvement (MMI) 6 weeks after her second epidural steroid injection, and that she could work on an unrestricted basis. (RX 2)

Dr. Vasconcelles re-examined Petitioner on September 5, 2014 noting Petitioner had been off work for more than one year due to chronic pain syndrome induced by an accident at work. Petitioner was currently waiting to find out from the DSS about her disability status and also from her employer's disability program. Petitioner reported that her inability to work had resulted in financial strains that have forced her into Medicaid for her health care and leading her to be on the verge of a divorce and bankruptcy due to her issues. Dr. Vasconcelles' diagnosis was noted as lower back pain and chronic pain syndrome. The doctor referred Petitioner to another attorney for a second opinion regarding her workers' compensation case and she was to return in three months. (PX 1)

Dr. Tabatabai issued another note after examining Petitioner on October 16, 2014. He noted Petitioner remained depressed, anxious, and overwhelmed and might require partial hospital care or inpatient care in the near future. In the meantime, he felt she met the criteria to be considered disabled. Her progress remained guarded. (PX7)

Petitioner followed up with Dr. Vasconcelles on January 29, 2015 regarding her history of "fibromyalgia that was post traumatic due to an injury at work." Petitioner reported muscle tension headaches that appeared with weather changes and trigger point pain. She was maintaining on Lyrica, Vicodin, heat rest and stretching exercises. Petitioner also reported the past winter having been bad for her due to pain and the inability to exercise due to weather. Petitioner's complaints also include more forgetfulness and "fogginess" so that she frequently would forget to take her medication. Petitioner was noted to be separated and working part-time performing administrative work at a local church.

Petitioner stopped working at Parkway Christian Church as of March 8, 2015. According to church records, the Church was having "several problems with her work." While there she earned $11,058.00. (PX 11; RX 9)

On June 15, 2015 Petitioner presented to Dr. Vasconcelles in follow-up after a motor vehicle accident. Dr. Vasconcelles noted that Petitioner was a restrained driver in a car and her gas pedal stuck causing her to strike a brick building. Petitioner was removed from the car by emergency personnel and seen at the emergency room where a CT scan was taken of her head and neck as well as a chest x-ray and echocardiogram. Petitioner was diagnosed with a fractured sternum. Petitioner's history of chronic pain was also noted with Petitioner reportedly having to use her Vicodin regularly. (PX 1)

Petitioner saw Dr. Vasconcelles on July 6, 2015 reporting she had fractured her sternum in a motor vehicle accident on June 9, 2015. Petitioner reported doing better and being able to be active in her yard again with no new symptoms of concern. Petitioner reported radiating pain into her left upper extremity one evening but it had resolved. The motor vehicle accident was due to a defect in her car. Dr. Vasconcelles noted Petitioner had an ongoing workers' compensation case with her previous employer and would be due for a visit for reassessment of her issues regarding that injury in September. (PX 1)

Petitioner presented for a recheck on her chronic pain syndrome/fibromyalgia on September 11, 2015 telling Dr. Vasconcelles she was having a bad day and denying any recent injury or activity to cause her worsening pain. Petitioner was using Vicodin for days when the pain was really bad. She reported new symptoms of burning pain in her upper back as though it was in her skin. Petitioner also reported occasional knee pain. Petitioner was taking Lyrica, exercising by walking, and had DVDs for Pilates and Yoga. Petitioner was working a part-time job and noting Medicare was saying she might be making too much (money) and might be dropped. Petitioner also told the doctor she had been reading on the Mayo web site about a new blood test for diagnosing fibromyalgia. Petitioner was to call with the name of the blood test and the doctor would order it. (PX 1)

Petitioner began working for Hospital Sisters Health System (HSHS) on September 20, 2015 on a part-time basis as she averaged about twenty hours per week. She was paid $11.10 per hour. (PX 10)

Dr. Vasconcelles performed a quarterly disability check-up of Petitioner on December 11, 2015. The doctor noted that Petitioner had post-traumatic induced soft tissue pain and had been on medical leave for three years from her previous job. Petitioner was working part-time in the afternoons at HSHS answering phones in its IT office. Petitioner reported pain flare-ups with weather changes and facial swelling. Petitioner was engaged in stretching, hot showers, heating pads, and medication to help with the pain. She was also trying yoga as that had helped in the past. Petitioner's recent bone density scan showed osteoporosis for which she was started on Fosomax. Petitioner's Lyrica dosage was increased. Work ability was not addressed. (PX 1)

Petitioner was examined by Dr. Vasconcelles on January 14, 2016 regarding dental issues as she had upcoming dental work scheduled. Dr. Vasconcelles' notes indicate that she also refilled Petitioner's Hydrocodone for her back pain as it was time to do so. (PX 1)

On March 11, 2016, Petitioner again presented to Dr. Vasconcelles in follow-up for her chronic pain syndrome/fibromyalgia which "was felt to be caused by an accident several years ago." Petitioner reported a recent flare of her pain "perhaps due to the weather" and noted it was different from her normal upper and lower back pain in that it radiated into her right proximal lateral thigh. Petitioner reported compliance with her use of Lyrica, Vicodin, and stretching exercise and denied any recent injury or illness. Petitioner reported that she was working, but felt "the stress of work may be factoring into her pain flare." Dr. Vasconcelles further noted a history of degenerative disc disease in Petitioner's spine with mild disc herniations that could case flare-ups of pain also. Petitioner was reportedly going into arbitration with her attorney for payment of disability from her first employer and then with SRS. Dr. Vasconcelles referred Petitioner to a therapist, Kay Gottrich, for help dealing with the chronic pain and depression. She was given an off work slip for that visit and Monday due to chronic pain and fatigue. (PX1)

On April 29, 2016, Petitioner returned to see Dr. Vasconcelles in follow-up to "continue disability leave due to a work injury." Dr. Vasconcelles noted Petitioner had a chronic pain syndrome "felt to be generated by this injury" and which was being managed with "tonic medication" including Lyrica and Vicodin. Petitioner was reporting worsening pain and increased use of Vicodin. Dr. Vasconcelles further noted that she "was really there that day" for "documentation of fibromyalgia which has not been officially documented in her chart as it is under her diagnosis of chronic pain syndrome." Petitioner was noted to have pain at her left thoracic and lumbar musculature that has been bothering her for a few days. Petitioner told Dr. Vasconcelles that she was working at a part-time job but having issues with continued pain and fatigue which made it very difficult to do the job and, indeed, expressed uncertainty as to whether she could continue the job. Dr. Vasconcelles further noted that Petitioner was in the process of getting permanent disability from her prior employer. She was also seeing a therapist as she was having a lot of depressive symptoms aggravating her pain. Petitioner was taking medication to help with the pain and psychological factors going with it. Dr. Vasconcelles gave Petitioner a note for her to leave her current job due to her chronic pain syndrome and fatigue and a copy of the office visit note was given to her for forwarding to her attorney. (PX1)

In a Health Status Form dated May 5, 2016 (and unsigned) Petitioner was noted to be unable to work due to "current medical issues." Her diagnosis was listed as chronic pain syndrome with fatigue.

Petitioner's last day of work with HSHS was May 28, 2016. (PX 10)

Summary of the Arbitration Hearing

Petitioner's case proceeded to arbitration on October 24, 2016. The issues in dispute were causal connection, medical bills, temporary total disability, maintenance, and the nature and extent of Petitioner's injury. The witnesses included: Petitioner; Jennifer Cavanaugh, Layla McLean, Mark Gifford, and Peggy Henry.

Petitioner testified that prior to going to work for Respondent, she spent five years as the residency coordinator at SIU School of Medicine. Prior to that job Petitioner spent ten years at Hanson Professional Services as an administrative assistant. Petitioner testified to being a high school graduate and receiving a certificate from Jacksonville Business & Careers.

Petitioner was employed by Respondent on October 11, 2012, and had been so employed as an administrative assistant II for the preceding 5 years.

Petitioner further testified that she worked in the Debt Department as well as for the agency's Director when he was in Springfield. Petitioner testified that her job required her to process "capital release forms" (requests for money) and run errands to various other state agencies. She also did filing and was the back-up receptionist. When the Director was in town, she would set up meetings and run errands for him, including getting his lunch. When the directors changed, she had to help with the office move. Petitioner testified that she was responsible for a great deal of filing which required her to move throughout the office handling both big stacks of paper and bankers boxes weighing fifty to one hundred pounds. Petitioner believed she filed on a daily basis and moved banker's boxes on a monthly basis. She felt she spent 40% of her time on her feet and the remainder was spent sitting.

Petitioner testified that the fire alarm went off on October 11, 2012 and as she and other co-workers descended the stairs from the sixth floor of the building she fell ten to twelve steps hitting her head on the hand rail. Petitioner fell down an entire flight of concrete steps onto the landing below, striking her head as she fell.

Petitioner testified that she did not remember the actual fall, but she did remember ending up head first on the landing with her legs above on the stairs. She recalled being helped up by a co-worker Peggy Henry. She did not want to go to the hospital by ambulance, and called her husband, who transported her to Memorial Medical Center.

Petitioner testified that she did not remember a lot about her visit to Memorial Medical Center that "it was like I was in a smoke filled room." She recalled having x-rays of her knee and a CT scan of her head and neck. Her primary complaints at that time were in her head and neck. In

describing the location of the pain in her head at that time, Petitioner indicated the back of her head on the left side. Petitioner testified that she was diagnosed with a concussion and neck sprain.

Petitioner further testified that she was instructed to follow-up with her family physician, and did so, seeing Dr. Vasconcelles a week after the fall. When Petitioner saw Dr. Vasconcelles initially, her areas of complaint were her head, neck, and whole back, including pain down both her arms and legs as well as headaches. Initially, she was treated with medication and physical therapy. Petitioner testified that the therapy was of temporary benefit. Petitioner was next referred to a chiropractor, Dr. Venturini. Petitioner saw Dr. Venturini for six visits, and Petitioner testified to no relief from the chiropractic relief.

Petitioner denied ever having any problems or treatment for her neck, upper back, low back, or shoulders prior to this accident, and the arbitrator notes that no evidence was introduced to the contrary. Petitioner admitted that she had experienced migraine headaches periodically over the years prior to her injury. She described her migraines as affecting the front of her head, forehead area, and behind her eyes, as opposed to her post-injury headaches, which were more localized around the area where she struck her head.

Petitioner continued to work for the first few months after her injury. She testified that she had to call in often because of the pain, but that she did not ask for nor did her doctors authorize her to be off work. Instead, she used sick time and comp time when she was absent. Petitioner testified that in December she was allowed to take/use vacation days.

Petitioner further testified that as of January 16, 2013 she was off work and under the care of Dr. Vasconcelles. During the time, she was still experiencing neck and low back pain, as well as the headaches. In January, she was referred to Dr. Warach, who ordered various diagnostic testing, and then recommended a pain clinic for her neck and back. She saw Dr. Salvacion, who did two epidural injections for her low back. She testified that she did not get any relief from those. Petitioner next saw Dr. Pineda, and recalled that he had referred her back to the pain clinic. She returned to Dr. Salvacion and he referred her Marian Rehabilitation Institute in Wheaton. Petitioner testified that she was never evaluated there because it was not approved.

In late September 2013, Petitioner returned to work for Respondent, part-time for two weeks, and then full-time. She continued working until October 23, 2013. She understood that she was under restrictions on her return. Petitioner testified that she returned to her same job; however, her restrictions were not accommodated. She was doing a lot of running for the Director, and had to deliver bounded books for bond sales. She noticed that she could not keep up with the work because of the pain in her neck, shoulders, and back. The walking aggravated her back pain. Over the few weeks back, her symptoms got a lot worse, prompting her return to Dr. Vasconcelles. At that point, Dr. Vasconcelles took her off work. She testified that Dr. Vasconcelles's opinion on her work ability has not changed since that time.

Petitioner further testified that during this time period she was also seeing Dr. Tabatabai, a psychiatrist. Petitioner acknowledged a prior history of treatment with him for depression and anxiety but she had been able to work steadily without any lost time on account of either

condition. Petitioner described her anxiety and depression as being well managed up until her work accident but unmanageable thereafter. According to Petitioner, Dr. Tabatabai prescribed various medications and dosages to manage her symptoms and she recalled that the doctor suggested to her that it would be difficult for her to return to work.

Petitioner testified that Dr. Vasconcelles told her in October of 2013 that she needed to be on permanent disability and that her opinion on that hasn't changed since then.

Petitioner found part-time employment on her own with Parkway Church as a part-time secretary/receptionist. Petitioner worked for the Church until March 2015, when she was dismissed. She testified that the senior interim pastor told her she was being let go because of a "failure to improve." Asked whether she was able to complete the tasks of that job, Petitioner said she would get it done, but her work was not satisfactory, she would make frequent mistakes. She attributed that to her pain medications, which made her "foggy." She noted that she was taking ever more pain medications during the time she worked there because she was experiencing increased pain.

Petitioner testified that after losing her job at the church she didn't start looking for work right away because she wasn't physically or mentally able to do so.

Petitioner testified that she was in a car accident in June of 2015 and broke her sternum. For a short period of time she felt an increase in her neck and back problems but it subsided after about a week.

Petitioner also testified that in the fall of 2015, she found another part-time job working for HSHS as a switchboard operator four hours per day. Petitioner indicated that the job was not physically demanding. That job required more constant sitting, which increased her dependence on her pain medications. She said her concentration was not up to par. She testified that the work was also mentally stressful, as she was handling multiple calls from multiple systems, and having to re-route the calls around multiple facilities. Petitioner testified that she quit her job in May of 2016 as she "gave up."

At this point in the hearing, Petitioner stood up for a few minutes and then sat down again.

Petitioner testified that prior to her work accident she spent a lot of time with her two grandchildren attending activities they were involved in; however, as a result of the accident she finds traveling the sixty miles to visit them hard on her as it is difficult to handle the walking and sitting. On a day to day basis, Petitioner tries to set a daily goal to reach. She has difficulty doing multiple loads of laundry or cleaning her floor.

Petitioner testified that she has been taking Hydrocodone since the accident with the need to periodically increase the dosage. She further testified that she still experiences dizzy spells and, at times, her balance isn't good. She feels some of these problems may be related to the medications she takes as a result of her accident. Petitioner also, on a monthly basis, experiences headaches especially when the barometric pressure changes.

Petitioner testified that she continues to treat with Dr. Vasconcelles and Dr. Tabatabai.

On cross-examination Petitioner added that her job with Respondent occasionally required her to use a step ladder for filing. She estimated that she spent half her time at her desk and half her time filing although the amount of time spent at her desk could increase towards the end of the fiscal year. Petitioner confirmed that she worked 7.5 to 16 hours per day.

Petitioner also testified that she no longer gardens as she once did and that her grandchildren come and visit her rather than her going to them.

On redirect examination Petitioner testified that she returned to work in October of 2013 per Dr. Pineda who felt she could do so. Petitioner tried and couldn't keep up as her work duties would increase her back, neck, and shoulder pain and cause right leg pain and limping. Petitioner testified that on her last day at work her supervisor asked if she had checked with the director to see if he needed her beyond 5:00 p.m.

Petitioner's witness, Peggy Henry, testified to observing Petitioner falling down 14 concrete steps onto the landing below. She also testified regarding Petitioner's job duties. At the time of Petitioner's injury, her job involved typing, moving offices and files, moving furniture. She would have had to sort files, throwing old files into a dumpster. The files had to be retrieved from shelves in boxes, and pulled down to sort through them. She described these as bankers boxes. She estimated that the boxes would weigh between 17 and 20 pounds. She said Petitioner returned to the same job, but missed a lot of work because she would get light-headed and dizzy.

Ms. Henry also testified regarding Petitioner's efforts to return to work in late September 2013. According to her, Petitioner was trying to get Phil's office moved and her office moved. They had to separate those offices, move furniture, move chairs, move files into separate offices which required them to move everything, including telephones.

Jennifer Cavanaugh testified on behalf of Respondent. Ms. Cavanaugh was employed in the same agency/office as Petitioner as assistant technology fiscal operations manager. She was Petitioner's supervisor at the time of the accident. Ms. Cavanaugh testified generally as to what Petitioner's job duties would have entailed, and said that after her accident she would not have asked Petitioner to lift or move anything greater than 10 pounds. Ms. Cavanaugh also admitted that Petitioner also worked as a part of the debt management group, which was not under her supervision, and it would have also been assigning tasks for Petitioner to perform. She did not recall whether Petitioner had been asked to move the director's office in October of 2012 but it was likely. She further testified that there were people available to help with heavy lifting but she would have needed to ask. She also acknowledged that Petitioner would get work instructions from numerous people. Ms. Cavanaugh acknowledged that Petitioner took some time off in the fall of 2013 after returning to work for health reasons. She also acknowledged that Petitioner took time off between October of 2012 and January of 2013 for health reasons which she presumed stemmed from her accident. She acknowledged that Petitioner returned to work on September 24, 2013 after last working in January. When Petitioner returned to work in 2013 she voiced no complaints to Ms. Cavanaugh.

Layla McLean also testified for Respondent. She was/is the fiscal manager for Respondent and, as such, managed its workers' compensation claims. She testified regarding the general practices of the agency with respect to workers' compensation claims, and its efforts to accommodate restrictions. She also suggested that she had communicated to Petitioner to let it be known if she needed anything, whether she needed to walk around, take off for treatment, etc.

On cross-examination Ms. McLean admitted that when Petitioner returned to work in 2013, initially half-time hours, she was charged vacation days for the missed hours because she was no longer on workers' compensation at that time having been released her to come back per the independent medical exam with no restrictions. Ms. McLean was unsure if she was aware of any restrictions when Petitioner returned to work in September of 2013. She further testified that through e-mails back and forth with Petitioner, she advised Petitioner that they would be willing to take any means necessary to get her back to work and help her with anything she needed. Ms. McLean also testified to sending an e-mail to Petitioner asking her for clarification as to whether a previously sent e-mail was a resignation as she needed to clarify Petitioner's status. Ms. McLean also testified that she received Dr. Vasconcelles' note taking Petitioner off work completely in October of 2013.

Ms. McLean was unaware of any time between the accident and January 8, 2013 when Petitioner was working more than sixty hours per week. She further testified that Petitioner was placed on temporary total disability as of January 9, 2013.

Mark Gifford also testified. Mr. Gifford was formerly pastor at the church Petitioner worked at for a short time. He testified that he supervised her during her tenure at the church. Mr. Gifford testified that Petitioner was never unable to complete her work nor did she ever approach him advising that she was having difficulty completing her job duties. He agreed that she was ultimately fired from her position but that it wasn't because she couldn't complete her assigned tasks; rather, she was unable to advance in the position.

Respondent's Exhibit 5 contains a list of medical bills paid by Respondent.

The Arbitrator concludes:

Issue (F) Causal Connection:

Petitioner's current condition of ill-being is causally connected to her accident of October 11, 2012. This conclusion is based upon a chain of events and the medical records of Drs. Vasconcelles and Tabatabai. The Arbitrator further finds Petitioner to have been a credible witness.

Petitioner has been diagnosed with a neck sprain, low back sprain, post-concussion headaches, chronic pain syndrome/fibromyalgia, depression and anxiety. Petitioner's medical history did not include anything to suggest previous complaints to her neck, upper extremities, low back, or lower extremities. While Petitioner did have pre-existing migraine headaches, her post-injury headaches were of a different nature. She also had pre-existing depression, but her testimony and records would suggest that was well-controlled by medication, and that Petitioner had never

missed any time from work related to that issue. Prior to October 11, 2012 it appears that Petitioner was able to work full duty in a job that often involved long days and a great deal of activity. While her primary occupation required her to mainly sit or file, Petitioner was also an assistant to the agency director when he was in town which required a great deal of activity and running around on errands. Her testimony regarding her job duties was essentially unrebutted. Everything changed after October 11, 2012.

While the emergency room records weren't admitted into evidence they were readily available to both parties and it appears from Dr. Weiss' Section 12 exam report that he reviewed them. According to his report, Petitioner had complaints of a head and right knee pain at the E.R. Respondent's First Report of Injury mentioned head, back, elbow and right hip complaints. (RX 2, p. 4) After the accident Petitioner was treated for headaches, a neck strain and low back pain. While the latter did not materialize immediately it did so within a reasonable amount of time. While Dr. Vasconcelles noted Petitioner's low back complaints in March of 2013 were new and different she never stated they weren't unrelated. Furthermore, neither Dr. Weiss nor Dr. Pineda took issue with Petitioner's low back complaints. They both agreed she had sustained, at a minimum, a strain and/or temporary exacerbation. Respondent also stipulated to TTD benefits through June 5, 2013.

The Arbitrator has given consideration to the varied histories Petitioner provided to doctors regarding the onset of her complaints (gradual v. immediate). She finds no significant disparity in these histories as the bottom line is that Petitioner consistently associated them with her fall and, again, Respondent's examining doctors connected the low back strain, neck strain, and headaches to the fall.

The Arbitrator is aware that the records of Petitioner's treating doctors, especially Dr. Vasconcelles and Dr. Tabatabai, don't clearly indicate the doctors were aware of Petitioner's jobs with Parkway Church and HSHS; however, Petitioner testified that they were and her testimony was unrebutted. The Arbitrator is also aware that, at times, Petitioner's histories and representations to the doctors (such as in October and November of 2013 when she reported having demands put upon her to work 12-16 hours days and having to increase her Hydrocodone to get through a day which could require working up to thirteen hours) were not in accord with the realities of her return to work (work records showed working 7.5 hours per day) but, again, Petitioner testified to being asked to check with her director about staying late and Ms. McLean, while a supervisor for Petitioner, wasn't her only supervisor. Thus, the Arbitrator is unable to conclude that Petitioner's histories were so false as to render her not credible. The overwhelming weight of the medical evidence from the fall of 2013 suggests that Petitioner was struggling to return to work in her full capacity and while subsequent medical records might suggest additional factors (financial issues, marital problems, job performance stress, and workers' compensation issues/stresses) were playing a role in Petitioner's pain complaints, the accident remained "a factor" in her ongoing condition and difficulties. Petitioner has never returned to the physical and emotional condition she was in prior to her work accident.

The Arbitrator also notes that the medical records suggest Petitioner has some memory difficulties. It is not entirely clear if these relate directly to her physical trauma or the medications she takes to address the injuries sustained in her fall. Either way, the difficulties

relate to the accident and they, too, have been factored in addressing pertinent issues herein. Petitioner's memory difficulties/concentration issues were apparent during the hearing. That she may have been incorrect about a referral from Dr. Pineda to a pain clinic is not known. Perhaps, she was confused or misunderstood. Perhaps Dr. Pineda told her that but did not put it in his report. Dr. Pineda was not deposed.

In the end, Petitioner was a credible witness.

The Arbitrator is also aware that, for the most part, all of Petitioner's tests have been relatively benign with MRI scans showing degenerative changes but nothing acute. Petitioner's lower extremity studies were "fairly unremarkable" but did reflect a bilateral L5 radiculopathy. Petitioner's lower leg complaints have been limited to her right side and she injured her right knee during the fall, according to ER notes reviewed by Dr. Weiss. The Arbitrator is also cognizant that Dr. Vasconcelles' records occasionally referenced herniated discs when no other doctor ever described Petitioner's discs as herniated; rather, they were described as bulging. Nevertheless, Dr. Vasconcelles used the terms inter-changeably and she also had very thorough records on Petitioner as noted by the size of PX 1 and the inclusion of so many outside records initialed by her. As such, her opinions were well informed.

The Arbitrator has considered the role of the June 2015 motor vehicle accident and does not feel it broke the causation chain. Petitioner may have had a brief period of increased pain after the accident but records show she returned to her base-line (pre-car accident) within a short period of time.

Respondent has placed significant reliance on the opinions of its examining physicians – Dr. Pineda and Dr. Weiss. The Arbitrator is not persuaded by either, primarily because neither doctor reviewed all of Petitioner's treating records post-accident nor was either doctor was aware of Petitioner's treatment with her psychiatrist, the first visit of which occurred prior to her examination with Dr. Pineda. As such, neither doctor considered the impact of Petitioner's recurrent depression and anxiety in her symptoms of pain. While Dr. Weiss felt Petitioner was magnifying her symptoms, he was the only doctor to suggest it but, again, his report was not based upon a review of all her records. Indeed, Respondent never had Petitioner examined by a psychiatrist whatsoever. Furthermore, Dr. Weiss did not address the diagnosis of chronic pain, the recommendations of several of the treating physicians of a need for ongoing pain management for that pain, or the suggestion of a referral to an inpatient pain program to further evaluate and treat that pain. Dr. Pineda did not have a complete understanding of Petitioner's job duties for Respondent and, therefore, wasn't fully informed to assess her ability to return to work.

Issue (K) Temporary Total (TTD) and Temporary Partial (TPD) Benefits:

Petitioner was initially taken off work by Dr. Vasconcelles on January 10, 2013. Petitioner testified she began receiving TTD benefits on January 16, 2013. Ms. McLean testified it was January 9, 2013. Petitioner's time sheets show she last worked on January 8, 2013. The Arbitrator places the greatest reliance on Dr. Vasconcelles' note and finds Petitioner was entitled to temporary total disability benefits as of January 10, 2013. Thereafter Petitioner was released

to return to work with restrictions as of September 23, 2013 and Petitioner did, in fact, return to work on the 23rd. Petitioner is entitled to TTD benefits from January 10, 2013 through September 22, 2013, a period of 36 4/7 weeks. While Respondent maintains Petitioner is only entitled to TTD benefits until June 5, 2013, based upon the opinion of Dr. Weiss, the Arbitrator has found Dr. Weiss' opinion unpersuasive and she adopts her causation discussion above in support of her findings herein.

Petitioner was again taken off work by Dr. Vasconcelles as of October 25, 2013 and Dr. Vasconcelles has not released her to return to work for Respondent since then. Dr. Tabatabai has also kept Petitioner off work. As of March 4, 2014 Dr. Vasconcelles did not feel Petitioner would ever be able to return to her occupation. Dr. Tabatabai felt Petitioner, from a mental health perspective, was completely unable to manage a part-time or full-time job of any kind and that her chronic pain syndrome had contributed to both her physical and mental limitations. He felt she fit the criteria for disability status. As of October of 2014 Dr. Tabatabai's opinion remained unchanged and he even noted the possibility of partial hospital care.

Since October 25, 2013 Petitioner has been employed at two part-time jobs. She has been unable to succeed at either, having been terminated by the Church and having to quit with HSHS. Her earnings while working were minimal. Her testimony regarding her ability to handle the jobs was credible and unrebutted.

That Petitioner was able to briefly work at these jobs does not undermine Dr. Tabatabai's opinions. He did not feel she would be able to manage part-time or full-time work and, in actually, she was unable to do so. Petitioner is entitled to temporary partial for the two periods she was able to work part-time. Her earnings for Parkway Church totaled $11,058.00, which were her earnings over 48 weeks (4/15/14 – 3/16/15), or $230.38 per week. Based on her AWW with Respondent of $685.38, she is entitled to TPD of $303.33 per week for 48 weeks, or $14,559.84. Petitioner worked for HSHS for 36 weeks (9/20/15 – 5/23/16), and earned $8971.28, or $249.20 per week. She is entitled to TPD of $290.79 per week for 36 weeks, or $10,468.44.

Setting aside the periods for which Petitioner has been awarded temporary partial disability, Petitioner would be further entitled to TTD benefits for the following periods of time: October 25, 2013 through April 14, 2014 (24 4/7weeks); March 17, 2015 through September 19, 2015 (27 weeks); and May 29, 2016 through October 24, 2016 (21 2/7weeks).

Issue (J) Medical Bills:

Petitioner is awarded the medical bills contained in Petitioner's Exhibit 9. The medical bills contained in Petitioner's Exhibit 9 are all for treatment related to treatment for Petitioner's work-related injuries, and are awarded, subject to the fee schedule and any credit Respondent may have for payment of those bills either through workers' compensation or Petitioner's group insurance through Respondent. Respondent shall further reimburse Petitioner for her co-pays and out-of-pocket expenses as set forth in PX 9. All bills awarded are subject to the Medical Fee Schedule. Respondent shall hold Petitioner harmless from any claims for which Respondent is receiving its 8(j) credit.

Issue (L) Nature and Extent:

Petitioner is permanently and totally disabled as a result of her work accident of October 11, 2012 pursuant to Section 8(f) of the Act.

Dr. Vasconcelles has indicated that Petitioner cannot return to work. Dr. Tabatabai has offered the same opinion with respect to Petitioner's depression and anxiety, which he opined were aggravated by her injuries and resulting chronic pain. Notwithstanding those recommendations, Petitioner sought and obtained employment on her own and attempted to work on two separate occasions. From her description of both jobs, they were less physically demanding than her work with Respondent. However, in both jobs, Petitioner was unable to continue performing her duties. In the first job, she was terminated because she could not keep up with the work demands, which she attributed to her pain and her pain medications. In the second, her increased pain forced Dr. Vasconcelles to take her back off work. Since being taken off work on October 25, 2013 by Dr. Vasconcelles, Petitioner has never been released to return to work for Respondent by her or Dr. Tabatabai.

These efforts to work show that Petitioner was motivated to work, and motivated to try to continue to work even in the face of increased symptoms, but was unable to continue to do so. Both jobs were essentially sedentary in nature, but Petitioner could not perform them even 20 hours per week.

The Arbitrator therefore concludes that Petitioner is medically wholly and permanently disabled within the meaning of Section 8(f).

****

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marcus Shane Walker,
Petitioner,

vs. NO: 15 WC 11478

Southern Illinois University-Carbondale,
Respondent.

18IWCC0195

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 15, 2016 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.

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: MAR 30 2018

o-01/31/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WALKER, MARCUS SHANE
Employee/Petitioner

Case# **15WC011478**

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
Employer/Respondent

18IWCC0195

On 8/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% 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:

5236 CULLEY FEIST KUPPART & TAYLOR
KREIG TAYLOR
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

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

0558 ASSISTANT ATTORNEY GENERAL
NICOLE M WERNER
601 S UNIVERITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

AUG 15 2016

RUTH A. HASSIA, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0195

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

MARCUS SHANE WALKER
Employee/Petitioner

v.

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
Employer/Respondent

Case # **15** WC **11478**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **April 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 **Vocational Rehabilitation**

FINDINGS

On **December 23, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 $**N/A**; the average weekly wage was $**N/A**.

On the date of accident, Petitioner was **44** 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 **$12,561.58** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$12,561.58**.

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

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment on December 23, 2011. All benefits are denied. The Arbitrator makes no findings regarding the remaining issues.

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

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

Signature of Arbitrator

August 11, 2016
Date

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARCUS SHANE WALKER
Employee/Petitioner

18IWCC0195

v.

Case #: 15 WC 11478

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On his date of accident, December 23, 2014, Petitioner was 44 years old, single, with no dependent children. He was employed by Respondent as a temporary lamper at Southern Illinois University Carbondale and had been so employed since December 2, 2014. Previous to this position, he worked for Respondent as a temporary building service/maintenance worker from December 15, 2013, through May 31, 2014. At the time of trial Petitioner was not working for Respondent or any other employer. He testified his education consisted of a couple of years at a junior college, studying law enforcement, as well as some hours at John A. Logan College. He did not obtain an associate's degree. He previously worked as a correctional officer for the Department of Corrections for about four years, as an installer for Dish Network, as an underground coal miner, and a position in tactical security. Petitioner testified his work history consisted of jobs that required a lot of lifting, climbing, and dealing with conflict situations.

Petitioner testified that his job as a lamper required him to set and change the lights around campus. He consistently had to get up and down ladders and sometimes had to lift heavy things like boxes or ladders. In his previous position with Respondent, he was a building service worker, which involved doing janitorial work and a little bit of maintenance work. He testified it was a six-month job. He did not work for Respondent between the end of that job in May 2014 and the beginning of the lamper job in December 2014. Petitioner testified that his rate of pay as a lamper was $28.21 per hour, that he was hired to work forty hours a week, and that he worked second shift Monday through Friday.

On the date of accident, Petitioner was changing lights in Morris Library and was called by his co-worker Don to help him take a "Little Giant" ladder up the stairs to the engineering room in the library to change some lights. Petitioner estimated the ladder weighed about 100 pounds and took two individuals to carry. He testified that the stairs he and Don were walking up were steep and narrow, unlike regular stairs. As he was walking up the stairs carrying the

ladder with Don, he felt a shift and a pop in his left knee and then got a sharp pain and burning sensation on the inside of his knee. He did not think it was serious at the time, and he did not say anything to anyone and did not want to put his job in jeopardy. He finished out his shift and testified he had pain in his knee that was increasing. When he got home he iced and wrapped it. He testified he woke up about 1:30 or 2:00 a.m. and when he got up to use the restroom he could not put any weight on his knee. He called his supervisor Duane and told him what happened. Duane gave him the number for work comp and told him to call them. Petitioner testified he filled out a claim the next day and also spoke to Duane, Brad Dillard, and Phil Catton.

The day after the accident Petitioner's mother took him to the emergency room. He testified the doctor observed the swelling and instructed him to stay off his left leg until he was seen by his own doctor. He followed up with his primary doctor, who took him off work and started him in physical therapy. He testified he was paid by worker's comp for the time he was off work. He was ultimately referred by his primary doctor to an orthopedist, Dr. Wood, and was seen on March 25, 2015. Dr. Wood continued to keep him off work and he continued to be paid benefits while he was off. Dr. Wood referred him for additional therapy, which he attended, but which did not help. He ultimately had surgery on his left knee on May 12, 2015. He testified that he was paid for his time off work and that to his knowledge his bills were paid by worker's comp. Following surgery he continued to have pain and swelling in his left knee and continued to attend physical therapy. He testified he made minimal progress with therapy and eventually it was terminated by worker's comp, which he believed hurt his progress.

Petitioner testified that Dr. Wood eventually released him at maximum medical improvement on September 24, 2015. He placed permanent restrictions on his activities at that point, which included avoiding climbing and no lifting over 40 pounds. Petitioner testified his job with Respondent required him to consistently climb and to lift over 40 pounds, and he was not able to return to his position with those restrictions. Petitioner testified he has not been paid worker's compensation benefits since they were terminated on September 26, 2015. He testified he had been looking for work but had not found anything, and kept track of his efforts on the job log admitted as Petitioner's Exhibit 9. He believed he had a job with the sheriff's department in Harrisburg, but at the end of the hiring process he was told he could not be hired due to his lifting restrictions. The job would have paid $9-10 per hour. Petitioner testified he is in need of vocational assistance in helping him look for a job. The Arbitrator notes that the job log admitted (PX9) is four pages long and contains a total of 28 prospective employers contacted. The Arbitrator further notes that none of the pages contain any dates, either on the individual Employer lines or at the top of each page, to indicate date of contact.

With regard to his current symptoms and complaints, Petitioner testified he has trouble trying to walk and he gets fatigued, which leads to the burning sensation returning in the left side of his knee. He has weakness with no strength in the left knee, and walking up stairs gives him problems. He currently takes Norco for the pain, which is prescribed by Penny Smith in his primary physician's office. He testified if he stays off his knee the pain is not nearly as bad. Prior to the accident he did not have any complaints of pain in his left leg, nor did he have any difficulties performing his job duties. Prior to the accident he played basketball and lifted weights, and is no longer able to do either.

On cross-examination, Petitioner acknowledged that both jobs he held at SIU had been temporary positions. He testified he was told by Phil Catton that the lamper position was going to be permanent, but he was not given specifics on it. He was unaware of any kind of examination he would need to take to be permanent full time at SIU, and testified he had not taken a state exam. Petitioner acknowledged he does not have a college degree and also acknowledged that he had several jobs in many different fields. He testified he worked second shift, which was 3:00 to 11:00 p.m., and admitted he did not work a complete shift most of the time he was employed as a lamper, as he had to leave to catch the bus home at 10:30 or 11:00. He did not have a driver's license at that time, so relied on public transportation, but testified he did have a license at the time of trial.

Petitioner acknowledged he had a full thickness cartilage defect in his right knee previously and had undergone two surgeries on his right knee. He testified he had not applied for Social Security Disability, and has been looking for work since he was released at MMI on September 24, 2015. Petitioner reviewed the job log (PX9) and testified it listed 28 jobs he had applied for between September 2015 and April 2016. He admitted, however, there was a period of time after November 23, 2015, that he did not look for a job, due to a death in the family.

Respondent presented witness Donald Morehead, who is a sub-foreman with building services for Respondent. Mr. Morehead testified he was working on December 23, 2014, and he recalled carrying a ladder with Petitioner on that date. The ladder was big and bulky and weighed around 100 pounds. It can be carried by one person for a short distance, but not up a flight of stairs, which required two people. He testified the ladder was on the top floor of the library and had to be carried to the mechanical room above that in order to replace some lamps. The ladder had to be carried up a flight of stairs, followed by a turn, and then up a shorter flight of stairs. The lamps were changed in the mechanical room and then he and Petitioner carried the ladder back down to the top floor of the library and put it on a cart to be wheeled out to the truck. Mr. Morehead testified both he and Petitioner were carrying the ladder and that he was behind Petitioner on the way up the stairs. He did not see Petitioner stumble, fall, or misstep.

After that job was completed Mr. Morehead went to another job, but about 10:00 p.m. he went back to the library to pick up Petitioner, as he had been asked to take him to the bus stop. He testified he did not see anything out of the ordinary with Petitioner at that time, and Petitioner did not indicate he had experienced any kind of injury. He testified that someone who worked that shift would take Petitioner to the bus at around the same time. Mr. Morehead identified the Witness Report he filled out, marked as Respondent's Exhibit 6, and testified it accurately reflected what he recalled from the events of that day. He testified that filling out this report was standard procedure when an accident occurred.

Mr. Morehead testified Petitioner was hired on an "extra help contract" for the lamper position, and that it was a temporary position. It was temporary because the person who held the lamper position had been in a motorcycle accident, and Petitioner was filling in while she was recuperating. He testified there is only one lamper position on campus for the academic side, and that he was needed back in his position as a sub-foreman, so Respondent hired a temporary lamper until the other person returned from her recuperation. He testified there is a state exam that must be taken in order to become a permanent full time employee.

On cross-examination, Mr. Morehead testified his position at the time of Petitioner's accident was fill-in lamper. He had been in that position for about six weeks prior to the accident, returned to his sub-foreman position for about six weeks, and went back to the lamper position to fill in again in August 2015. He testified he sometimes worked with Petitioner, depending on the job requirements of what the foreman needed, and that he helped train Petitioner. He was not involved in the hiring and firing of individuals, but based on his personal knowledge, Petitioner's position was not going to be permanent. Mr. Morehead testified that a temporary employee's hourly rate depends on the job title and the union they are affiliated with. His understanding was that Petitioner's rate of pay was $28.21 an hour, and that he was to work approximately 40 hours a week. He testified Petitioner was in a training phase, that there was a learning curve, and that he did not have any problems with Petitioner.

Respondent presented witness Jeni Batson, who is the human resources officer and worker's compensation coordinator for Respondent. She testified that in her position she has access to, and is familiar with, employees' personnel and worker's compensation files. She identified Respondent's Exhibit 7 as the wage statement that she prepared to calculate Petitioner's average weekly wage. She testified it accurately reflected the document she created, which showed Petitioner's earnings between December 15, 2013, and May 31, 2014. She testified that during that six month period Petitioner was an extra help position building service worker, which is a temporary position. The hourly rate for that position was $14.76. Ms. Batson testified Petitioner was hired again in a temporary extra help position as a lamper with the physical plant, at an hourly rate of $28.21. She testified that the initial contract date for the extra help lamper position was from December 2, 2014, to June 30, 2015, but it was terminated on January 23, 2015, as the permanent employee Petitioner was replacing returned to work from a non-occupational disability leave. The temporary position was terminated at that point.

On cross-examination, Ms. Batson acknowledged that Petitioner was paid worker's compensation benefits from the time of his injury until September 26, 2015, and that at least some of Petitioner's medical had been paid. She was unaware of which bills were paid and which were not. Her understanding was that Petitioner's claim was initially approved by the claims administrator, Tri-Star. She agreed that when Petitioner was hired as a temporary lamper his hourly rate was $28.21 and that was for 40 hours per week.

Petitioner was recalled as a rebuttal witness. He testified Mr. Morehead's testimony as to the facts of carrying the ladder up the stairs was correct. He testified he did not tell Mr. Morehead that he had done anything to his knee while walking up the stairs with the ladder, as he did not want him to know. Upon prompting by his attorney, he testified he was concerned that if he filed a claim he would lose his job.

An Employer's First Report of Injury was completed on December 24, 2014, which indicated that Petitioner stated he was walking up stairs the night before and his left knee buckled. He further stated that after sleeping and not being on it, he stood up and felt pain like a bolt of lightening. RX1.

Petitioner first presented for treatment at 9:30 a.m. on December 24, 2014, when he went to the emergency room at Ferrell Hospital. He reported that while moving a ladder up stairs at work the previous night his left knee gave way. He denied falling. He stated the pain continually increased through the night and increased with weight bearing. One of the handwritten notes from the hospital indicated Petitioner injured his knee when he fell off a ladder, and the Arbitrator notes this discrepancy is most likely due to an error in the recording of the history by that particular person. Left knee x-rays showed mild arthrosis about the patellofemoral and medial compartments, but no acute bone abnormality. The discharge diagnosis was left knee sprain of the medial collateral ligament. Petitioner was instructed to ice his knee every one to two hours, to use crutches for two to three days, and to use an ace wrap for seven to ten days. He was instructed to follow up with his family physician in two to five days, on or before December 30, 2014. There was no reference to whether or not Petitioner should remain off work. PX1.

Petitioner next sought treatment on January 5, 2015, when he presented to Ferrell Hospital Family Practice and was seen by Physician's Assistant Pennie Smith. He reported he injured his knee at work, was seen in the ER and told to stay off work until seen in that office, and that he needed to know what to do about work. Examination revealed edema and the assessment was knee sprain. Petitioner was prescribed Norco, was referred to physical therapy and was instructed to follow up in two weeks. PX2.

On January 8, 2015, Petitioner completed an Employee's Notice of Injury form. He reported he injured his left knee when he and Don Morehead were carrying a ladder up the stairs of the engineering room in the library. He indicated he did not report it on the day it occurred because when it first happened he did not realize it was as bad as it was, and it got progressively worse through the course of the night, to the point he could not put weight on it. He stated he did not say anything at the time and did not know whether Don Morehead witnessed the incident or not. RX2.

On January 8, 2015, a Supervisor's Report of Injury was completed by William Everly. It was noted on the report that Mr. Everly was the fill-in foreman on duty at the time of the injury. He stated he did not receive notice of the accident and the details of the accident and injury were listed as unknown. RX4.

On January 8, 2015, a Witness Report was completed by Don Morehead. He stated he did not see the accident and that nothing was said to him about an injury during the time in question. He stated Petitioner assisted moving a ladder up a small flight of stairs, that Petitioner was in front of him during this process, and that he never noticed any change in Petitioner, as if he was injured. He further stated that later in the evening he was with Petitioner and never noticed he was injured. Petitioner was walking fine until Mr. Morehead took him to the bus stop at 10:00 p.m. He reiterated he saw nothing and heard nothing when moving the ladder. RX6.

On January 12, 2015, a Supervisor's Report of Injury was completed by Duane Spencer, Electrician Foreman. He stated Petitioner reported helping a co-worker lift a ladder when his knee gave out. He thought he just twisted it and could put weight on it at that time. Petitioner reported he rode the bus home and when he got off the bus he could barely walk. Mr. Spencer

reported that at 3:00 a.m. Petitioner texted him and reported he was unable to put weight on his left knee. He further stated he was off duty the night of the alleged incident and that the temporarily upgraded foreman that evening was Chester Everly. RX3.

On January 20, 2015, Petitioner underwent an initial physical therapy evaluation at Strictly Rehab/Ferrell Hospital, upon referral by PA Smith. He reported he was at work, stepping up steps, when his left knee gave way, buckled, and went out on him. He finished his shift and after work he was unable to walk or put weight on it. He reported he was not currently working and that he had been resting, icing, and wrapping his knee. He reported prior surgery to his right knee and a three-level fusion. He stated he worked as a lamper at SIU and that he needed to be able to climb ladders for his job. He complained of sharp, shooting, nagging pain on the medial side of his left knee, which was constant. It was noted he had no ambulation aides with him at the evaluation and he was wearing a loose ace wrap around the outside of his pant leg. He had a mild limp on the left when he ambulated. Assessment was possible meniscus tear, but the therapist was unable to fully assess due to Petitioner guarding with all testing and palpation. It was noted there was no edema or decreased quadricep tone. It was recommended he discontinue the use of the ace wrap, as it provided no support, and work on ambulation. Petitioner participated in therapy from January 20, 2015, through March 12, 2015. He reported continued pain toward the inside of the knee and difficulty with weight bearing and ambulating on stairs. It was noted that his range of motion and strength were essentially unchanged. It was further noted that an MRI had been requested and was awaiting approval. PX3.

On March 13, 2015, Petitioner underwent a left knee MRI, which revealed (1) moderate arthrosis about the patellofemoral, medial compartments with mild arthrosis laterally, and full thickness cartilage defect of the medial femoral condyle; (2) small joint effusion without synovitis; (3) moderate chondromalacia; and (4) popliteal cyst measuring 3.4 x 4.5 x4.7. PX5.

Petitioner returned to PA Smith on March 18, 2015. It was noted he had been attending physical therapy and had not been able to work due to instability in his left knee. PA Smith reviewed the MRI findings with Petitioner and referred him to an orthopedic surgeon. He was kept off work. PX5.

On March 25, 2015, Petitioner presented to Dr. John Wood at The Orthopaedic Institute of Southern Illinois. He completed several intake forms, on which he reported he had injured his left knee at work while carrying a ladder up stairs. He reported to Dr. Wood that he was carrying a ladder up some stairs when his left knee gave way, that his symptoms were unchanged, and that physical therapy had not helped. Dr. Wood reviewed the MRI film, which he interpreted as showing moderate arthrosis of the patellofemoral joint with a full-thickness cartilage defect. Petitioner reported he had mild swelling following the injury and had tried occasional anti-inflammatories. He reported they did not help and that he was interested in surgery. On examination, Petitioner's left knee had crepitation, positive McMurray's with pain referable to the medial joint line, and mildly positive patellofemoral compression. Assessment was osteochondritis dissecans. Dr. Wood opined Petitioner sustained a traumatic injury to his medial femoral condyle that resulted in a full-thickness cartilage defect. He noted Petitioner had a similar problem on the opposite knee which was treated with surgery, but Petitioner denied any pain on the left prior to the reported accident. He further opined that, although Petitioner may

have surgery, the results were fairly poor. Dr. Wood injected the left knee and ordered physical therapy. He allowed Petitioner to work with restrictions of walking no more than 15 minutes per hour, no lifting, no carrying, and no climbing. PX5.

Petitioner presented to physical therapy on April 2, 2015. It was noted he was unchanged since discharge on March 20, 2015, and that he was limited with progressing into higher level activities. The therapist believed Petitioner as at his maximum potential with therapy until further intervention by his physician. She spoke with Petitioner's nurse case manager, who agreed. On April 7, 2015, the nurse case manager reported to the therapist that Dr. Wood wanted Petitioner seen until his follow up appointment on April 15, 2015. He was seen on April 9, at which time he reported his knee felt better for two days after the injection, but then the pain had gone back to the same as before. Petitioner was seen on April 10, 13, and 14, and on May 11, 2015, at which time he was discharged pending surgery. PX3.

On April 15, 2015, Petitioner returned to Dr. Wood and reported his symptoms had not changed and were moderate to severe. He reported the injection had not helped significantly. On examination, Petitioner ambulated with a slow steady gait and was very protective of his left leg. He had slight effusion and had discomfort with McMurray's test but no palpable pop. Assessment was traumatic osteochondritis of the left knee and surgery was recommended, as conservative care had failed. PX5.

On May 12, 2015, Petitioner underwent surgery on his left knee. Procedures performed were chondroplasty with osteochondral pick medial compartment, chondroplasty with osteochondral pick patellofemoral joint, and extensive synovectomy. Post-operative diagnoses were osteochondral defect of the medial femoral condyle, osteochondral injury of the patellofemoral joint, and extensive synovitis. He followed up with Dr. Wood on May 28, 2015. He was to start using a continued passive motion machine (CPM) and was kept off work at that time. PX6.

On June 23, 2015, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Richard Lehman of U.S. Center for Sports Medicine. He gave a history of injuring his left knee when it gave way when going up stairs. He complained of significant swelling in the left calf, significant left knee pain, pain with bending, and soreness in the left knee. He also complained of significant swelling in his right calf. He reported he had never had an injury to his left knee before. He further reported he had had significant swelling in his lower extremities which had been problematic for a long period of time, with the swelling in his lower leg actually causing some skin damage. Petitioner stated he climbed ladders and installed lighting as part of his job. He reported past right knee surgery, right ankle surgery, and back fusion. RX8.

Examination by Dr. Lehman revealed post-surgical healed portals in the medial and lateral aspect of the knee. Petitioner did not have any swelling intraarticularly. Dr. Lehman noted, however, that Petitioner's lower leg was grossly edematous to the point of having venous stasis disease and venous ulcers. Dr. Lehman noted there was no anterior or posterior instability and McMurray's test was negative. Petitioner had diffuse tenderness in the patellofemoral articulation and significant grinding. There was no evidence of laxity. There was some grinding

in the anterior aspect of the knee, which appeared to be inconsequential. Dr. Lehman noted the biggest problem was swelling. RX8.

Dr. Lehman reviewed treatment records to date. He also reviewed x-rays taken in the office, which did not show any acute fracture or other acute pathology. Petitioner's pre-operative MRI likewise showed no acute effusion or acute changes. He also reviewed Petitioner's operative report and noted Petitioner's main disease pattern was degenerative. He noted there was no bone marrow fluid on the MRI, indicating no apparent acute component to the condition. Although Dr. Wood noted some of the chondral breakdown was acute, Dr. Lehman opined this was not corroborated by the MRI, which showed moderate arthrosis about the patellofemoral joint medial compartments with minimal effusion. He noted there did not appear to be any type of bony changes. Dr. Lehman noted mild degenerative spurring throughout the knee and thinning of the articular cartilage. RX8.

Dr. Lehman opined Petitioner's preexisting problems included morbid obesity, possible congestive heart failure, long-standing problems with his contralateral knee, and significant overload due to his accentuated BMI. Objectively, Petitioner had excellent range of motion and his knee was stable. He had mild grinding, had no varus or valgus instability, and the patella tracked centrally. He had significant lower extremity peripheral edema, which Dr. Lehman opined was secondary to congestive heart failure. His examination was good other than his severe swelling. RX8.

Dr. Lehman diagnosed Petitioner with preexisting degenerative arthritis and congestive heart failure. He opined there was no causal relationship between Petitioner's objective findings and the accident. He did not believe the incident of simply walking up a step and having Petitioner's knee give way was the etiology for the problems he had. He further did not believe there was a causal connection between the operative findings and Petitioner's symptoms, the severity of arthritis, or the pathology noted on the MRI, as the findings appeared to be chronic and long term rather than acute. RX8.

Dr. Lehman opined Petitioner's medical treatment had been reasonable to date, but now needed to focus on his peripheral vascular disease. He opined Petitioner had had excellent care and treatment for his knee, but that it was not in anyway related to his work injury. He believed Petitioner's prognosis was poor, due to his obesity and the amount of severe degenerative arthritis in his knee. He stated Petitioner was able to work with no repetitive squatting or kneeling, and limited stairs and weight carrying. Dr. Lehman opined Petitioner was at maximum medical improvement as respects his work injury and needed no further treatment; however, he did need to have his lower leg addressed to resolve the swelling, which was unrelated to his job or the injury. RX8.

Petitioner returned to Dr. Wood on June 24, 2015. He reported some increased pain in his right knee due to increased pressure on it, and it was noted he had some chronic problems with the right knee. He was allowed to return to full weightbearing and to return to work with restrictions of standing or walking no more than 15 minutes per hour, no climbing, and no lifting or carrying more than 15 pounds. He was referred to physical therapy. PX7.

On June 30, 2015, Petitioner underwent an initial physical therapy evaluation. He reported edema and difficulty walking, and stated his knee "feels weird". On July 1, he attended therapy and inquired about being able to lift weights in his arms. He was advised he should be able to do biceps, triceps, chest, and shoulders if sitting in a chair and someone handed him the weights, but that he was not to do standing arm exercises or lifting arm weights while standing or pick the weights up by himself. Petitioner attended therapy on July 6, 8, and 10, 2015. PX4.

Petitioner returned to Dr. Wood on July 22, 2015, and complained of moderate pain and weakness. He reported he had recently been hospitalized for pneumonia, and physical therapy had therefore been postponed. On examination, Petitioner ambulated with a good steady gait with no assistive device. Dr. Wood noted his recent hospitalization and pausing of therapy would slow down his recovery. Petitioner's work restrictions were continued. PX7.

Petitioner participated in therapy on July 28 and 31, and August 4, 7, 13, 14, and 18, 2015, and reported intermittent worsening of his pain. PX4.

On August 19, 2015, Petitioner returned to Dr. Wood with complaints of intermittent pain and swelling. Examination revealed an antalgic gait, mild swelling, and tenderness over the medial joint line. Petitioner was released to return to work four hours a day for three weeks, then to full duties. He was to continue therapy. Dr. Wood noted Petitioner was "at significantly higher risk for long-term arthritis". PX7.

Petitioner participated in physical therapy on August 24, September 8, 11, 17, and 28. He reported on September 8, 2015, that he had not heard from work about returning, as they did not have half days available. He was discharged on September 28, 2015. PX4.

On September 24, 2015, Petitioner followed up with Dr. Wood, who noted he had gone through the post-operative protocol of nonweightbearing with continued passive motion machine and therapy. He further noted Petitioner had recently been in the hospital for increased blood pressure. Dr. Wood opined that Petitioner was at maximum medical improvement. He advised he should avoid ballistic activity, running, impact activities, carrying heavy loads, and doing a lot of climbing particularly on ladders. He noted these activities tended to aggravate Petitioner's knee. Dr. Wood further opined that Petitioner would likely need future care for arthritis, which was post-traumatic and due to his work injury. Dr. Wood recommended and ordered a Functional Capacity Evaluation. PX7.

Dr. Wood testified by way of deposition on December 2, 2015. He is a Board Certified Orthopedic Surgeon with a subspecialty certification in sports medicine. His practice includes work with the knee, hip, shoulder, elbow, and hand. He testified consistent with Petitioner's treating records. His assessment at the initial examination was traumatic osteochondritic defect, or osteochondritis dissecans. He explained that the surface of the knee joint, the articular cartilage, can be sheared off, taking a piece of cartilage and a piece of bone with it, leaving behind exposed bone. The exposed bone does not have any cushion effect, which is what arthritis starts as. Dr. Wood testified this condition can be caused by or aggravated by a traumatic injury, such as the one sustained by Petitioner. He further testified that Petitioner's left

knee condition was caused by his work injury, based on the fact that Petitioner had no symptoms before this injury, and did have symptoms after the injury. PX8.

Dr. Wood testified he treated Petitioner conservatively for a period, and eventually performed surgery. During surgery he found a fair amount of swelling within the knee, swollen tissue called synovitis. The meniscus was normal. Petitioner did have an osteochondritic defect, which Dr. Wood described as clearly traumatic. He described an arthritic abnormality as one where the cartilage is worn away to the point where bone is exposed. Dr. Wood testified when a patient has a traumatic event, there is a very different look to it. There is a sharp edge and a bloody hole, where the piece of bone and cartilage used to exist. He noted in Petitioner's surgery there was such a hole, which measured three millimeters by one centimeter, which is about half an inch. He testified that while that may sound relatively small, it was a fairly significant portion of cartilage to be missing from the knee. During surgery the area was debrided, with abnormal tissue removed and edges smoothed. Dr. Wood testified that based on a reasonable degree of medical certainty, Petitioner's need for surgery was related to his work accident. PX8.

Dr. Wood testified Petitioner is at a significantly higher risk for long term arthritis because of his work injury. He explained arthritis is a loss of articular cartilage. The initial cartilage is called hyaline cartilage, which is extremely durable. With the surgery performed, cartilage is allowed to form, but it is fibrocartilage, which can last five to ten years but usually not much longer than that. Dr. Wood testified that the loss of cartilage with the injury, combined with the fact that the cartilage replacing it is not normal cartilage, it will lead to arthritis in most patients. He testified there is no way of knowing if Petitioner will need further treatment in the future, but that he is at higher risk. PX8.

Dr. Wood testified the last time he saw Petitioner was on September 24, 2015, at which time he recommended a functional capacity evaluation. He typically recommends this in worker's comp cases, particularly when there is permanency, and when there are medical legal issues involved, to give an idea of disability. He was not sure if the functional capacity evaluation was ever done in this case, as he never received a copy of one. PX8.

On cross-examination, Dr. Wood testified that approximately 60 percent of his practice is dedicated to the knee. He testified Petitioner gave a history of walking with a ladder on an incline when his knee buckled. He agreed that an osteochondral defect, when traumatic in nature, was usually caused by a twisting or direct impact. He disagreed that that kind of injury is frequently accompanied by a tear to other knee structures such as a ligament or tear, though it sometimes can be. He testified that walking up a step, carrying something, and the knee giving out can cause an osteochondral defect, as it can cause a shearing force within the knee. He described a twist as a shear force coming across the surface, which is the same thing as when a knee buckles, as the knee gives way and there is a tremendous amount of force as it flexes. PX8.

Dr. Wood agreed that Petitioner's MRI showed moderate arthrosis, or arthritis, and further agreed that arthritis takes a long time to develop. He testified Petitioner was 45 years old at the time he began treating, and he testified that moderate arthritis in a 45 year old's knee is becoming more frequent, though not common. He conceded that Petitioner's weight of about 270 pounds on a five foot ten inch frame created a load on his knee that would lead to faster

degeneration in the knee. He conceded it could also cause additional problems and make Petitioner more susceptible to injuries and problems with his knees. He agreed that Petitioner's BMI of 38.7 put him in the category of morbidly obese. Dr. Wood acknowledged that Petitioner had a history of multiple surgeries and problems with his right knee, and that it was common with someone his size to have problems in both knees. PX8.

Dr. Wood acknowledged it was possible Petitioner had just experienced pain on the date of injury, and that the incident had not actually caused the osteochondral defect. However, Petitioner told him specifically that he had not had problems with his left knee previously, that he had this incident, and then had a problem. In addition, what he found at the time of surgery looked traumatic and looked different than what simple arthritis or arthrosis very typically looks like. Dr. Wood conceded that if Petitioner had experienced prior problems or pain with his knee it could change his opinion, if he had a single traumatic episode that led to pretty significant increased pain within just a month or so before being seen. However, at the time of surgery he found not only chronic changes, the early arthritis, but also found traumatic lesions called osteochondritis dissecans. He testified there was something traumatic that occurred that left a hole behind. He testified the MRI showed a small amount of fluid within the joint, which is fairly typical, but agreed it did not show a great amount of fluid, a finding sometimes seen after injury. Dr. Wood testified it was unlikely that the swelling in Petitioner's leg was caused by congestive heart failure. PX8.

Dr. Wood confirmed that on August 19, 2015, he released Petitioner to return to work for four hours a day, five days a week, for three weeks. Then on September 14, 2015, he released him to return to work fully duty, with no restrictions. Then on September 24, 2015, he placed Petitioner at maximum medical improvement with permanent restrictions of avoiding running, jumping, impact activities, climbing, or lifting over 40 pounds. Dr. Wood testified that when he released Petitioner to full duty, he believed Petitioner would not do any of the activities that were beyond what he wanted him to do. However, when he saw Petitioner back for the MMI determination, he had to define what he could do long term and address not only his current job but also his future possibility of working. He acknowledged that this appeared inconsistent, but in fact was not. He conceded there is a possibility Petitioner could improve, but also a possibility he could get worse. He testified that although he recommended an FCE, whether it is done or not, it does not change what he is going to do with regard to recommendations. PX8.

Dr. Lehman testified by way of deposition on January 19, 2016. He is a Board Certified Orthopedic Surgeon with a subspecialty certification in sports medicine. His practice is primarily surgical and deals with sports medicine. A significant percentage of his practice is treating knee and shoulder injuries, including professional athletes, college athletes, and high school athletes. He performs 15 to 20 surgeries a week. He performs independent medical examinations only on an infrequent basis, and they comprise only about a half of one percent (.5%) of his practice. RX9.

Dr. Lehman testified consistent with his report of July 23, 2015. He testified he reviewed Petitioner's MRI films and noted there was minimal, if any, fluid in the knee, so there was no real effusion. He testified the MRI evidenced breakdown of the patellofemoral joint, arthritis of the patellofemoral joint and medial compartment, full thickness defect all the way down to the

bone on the medial femur, chondromalacia and arthritis on the back surface of the patella with areas of significant wear and some subchondral bone breakdown, and a large popliteal or Baker's cyst in the back portion of the knee. The MRI also showed arthritic changes of spurring on the medial aspect of the knee, which is normally seen after a long period of time with arthritis. He testified that generally an arthritic spur of the kind seen on Petitioner's MRI takes many years to develop. He explained that many years of microtrauma such as walking, especially in someone who is clinically obese, puts a lot of stress on their knee and the subsequent pathological process is the development of a spur. Dr. Lehman testified there was nothing on Petitioner's MRI films that suggested an acute component of his left knee condition. The same was true for the x-ray films reviewed from December 24, 2014, taken post-accident. RX9.

Dr. Lehman testified Petitioner had a full thickness cartilage defect in his left knee and that he had previously had the same problem in his right knee. He testified that when this defect is in both knees, it is considered "symmetrical" and is consistent with a degenerative arthritic process. It is common to have that condition in one knee, then in the other. Dr. Lehman explained that a full thickness cartilage defect is one in which the articular cartilage has been completely denuded, and that component of the knee is worn away or thin all the way down to the bone. Dr. Lehman testified he has researched this extensively and has written a number of articles and presented nationally and internationally on the topic. He has been treating full thickness cartilage defects for 30 years and has had 7,000 or 8,000 such cases. Dr. Lehman testified that when a full thickness cartilage defect is diffuse on the femur and on the back surface of the kneecap, as in Petitioner's situation, the cause is generally long-term and degenerative. Dr. Lehman testified the MRI did not show any bone marrow fluid, which indicated Petitioner did not have any effusion and that there was no acute process. He explained with an acute defect the knee would be extremely swollen, would stay swollen until the defect was addressed, and there would be bone marrow edema, which is stress where the honeycomb parts of the bone crack due to the stress. He explained if there was an acute component there would be bone marrow edema and either fluid or generally blood in the subchondral surface. He testified that he reviewed Petitioner's operative report and that there were no acute findings during surgery. RX9.

Dr. Lehman testified that Petitioner had comorbidities that caused or contributed to his left knee condition. The biggest comorbidity was Petitioner's weight of 290 pounds and his accentuated BMI of 41.6, which is considered morbidly obese and which stresses his knees. He testified there is an increase in the percentage of people with degenerative arthritis after a BMI of 29 or 30. A person with a BMI of 35 has a 60-70% chance of having degenerative arthritis. A person with a BMI of 40 or 41 has an 85% or better chance of having degenerative arthritis at Petitioner's age, and by age 60 100% of those people have degenerative arthritis. He testified there is a direct correlation between the percentage and severity of degenerative arthritis and a person's BMI, and after age 30 the curve is substantially steeper. RX9.

Dr. Lehman testified that after examining Petitioner, he believed his biggest problem was significant edema in the lower extremity and swelling to the point of having venous stasis disease. He testified the issue with that disease is that blood goes in but not much blood goes out, and it cannot be cured. It rarely, if ever, gets resolved and frequently ends up with an

amputation. He testified this had nothing to do with Petitioner's knee, but it looked very bad upon examination. RX9.

Dr. Lehman testified Petitioner's diagnosis was pre-existing degenerative arthritis of the left knee. He did not believe that walking up steps could be the mechanism of injury for the kind of damage that was found in Petitioner's knee. The biomechanics of walking up a step are pretty clear, and stress dissipated is in the patellofemoral joint underneath the knee, in the kneecap. Most of Petitioner's damage was found on the medial aspect of his knee, which is not where one would expect to find damage, based on the way the stress is dissipated in the patella and the trochlea. He testified Petitioner's disease process is totally incongruous with the history given in terms of the medial side of his knee and the wear patterns in the medial side and underneath the kneecap. Dr. Lehman testified Petitioner's left knee condition and his treatment for same were not related to the alleged work injury of December 23, 2014. Aside from causation, he testified Petitioner did not require any additional treatment and that he was at maximum medical improvement. He opined Petitioner could work with restrictions of no repetitive squatting or kneeling, but that those restrictions were not related to the alleged work accident. RX9.

Dr. Lehman testified if Petitioner challenged his knee with walking up or down stairs, walking on uneven ground, squatting, and the like, he would have had discomfort in the knee. He had two surgeries on the right knee and had a similar wear pattern. Based on that, he opined if Petitioner were to do normal activities he would have been potentially symptomatic. RX9.

On cross-examination, Dr. Lehman did not agree that it is easier to offer a causal relationship opinion when the person is examined closer to the date of the accident. He testified a causal opinion is most related to the doctor's experience, how much orthopedic research and literature he or she has done, their interest in the discipline, whether the doctor is actively doing research, and whether they subspecialize or have expertise in it. He testified the medical records he reviewed gave a history of Petitioner walking up steps with a heavy ladder, and the history Petitioner gave him was that he was walking up a step and had discomfort, which was a little different history. Dr. Lehman testified that with either history, carrying or not carrying a heavy ladder, his opinion was the same that it was not causally related to Petitioner's condition. He explained then when going up a stair, whether carrying something or not, stress is dissipated in the kneecap, and the pathology identified in Petitioner's MRI and operative report is not consistent with that mechanism. RX9.

Dr. Lehman acknowledged that arthritis can develop after an accident, but it is dependent upon many factors. He further acknowledged that Petitioner did not report he had prior symptoms, nor did he review medical records indicating prior symptoms. He agreed that a traumatic injury could aggravate someone's arthritis to the point of making it symptomatic, but only if there is a true traumatic injury. He testified that the mechanism of simply carrying a heavy ladder up or down stairs would not aggravate someone's preexisting arthritis. Rather, the mechanism of a twisting injury or a deceleration where the foot is planted and the body twists, is generally what would exacerbate a preexisting arthritic pattern. Dr. Lehman testified that an accident can aggravate arthritis, but that in this case there was no accident, as Petitioner was simply walking up stairs. RX9.

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). In order to satisfy the "arising out of" requirement of the act, the Petitioner must show the injury was in some way incidental to his employment, creating a causal connection between his employment and the injury. *Caterpillar Tractor Co. v. Indus. Comm'n.*, 129 Ill.2d 52, 58 (1989).

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident which arose out of and in the course of his employment.

Petitioner testified he was walking up the stairs when he "felt a shift and a pop", followed by a burning sensation and sharp pain on the inside of his left knee. He did not fall, stumble, misstep, twist his knee, or otherwise have an actual mechanism of an accident. He was merely walking up steps when he experienced pain in his left knee. Mr. Morehead testified he was with Petitioner at the time of the alleged accident, that he was behind him when going up the stairs, and that he did not see Petitioner stumble, fall, or misstep in any way. Mr. Morehead further testified that he did not see anything out of the ordinary with Petitioner, such as limping or favoring his left leg, the remainder of that day, or when he took him to the bus stop later.

The Arbitrator is mindful, and the record is clear, that Petitioner and Mr. Morehead were carrying a heavy ladder up the stairs at the time Petitioner stated he began having pain in his knee. However, there is no indication that carrying the ladder caused or contributed to Petitioner's knee hurting. The Arbitrator is also mindful that Petitioner testified the stairs were a little steeper than normal. However, again, there is no indication that this caused or contributed to Petitioner's knee spontaneously hurting. The record is consistent that Petitioner reported his knee simply "buckled" or "gave way" as he was walking up the stairs. The Arbitrator finds significant the history of injury as documented in the following:

1. Ferrell Hospital Emergency Room, December 24, 2014—The nurse wrote, "While moving ladder up the stairs last night left knee gave way. Denies fall." (PX1)
2. Employer's First Report of Injury, December 24, 2014—"Employee stated he was walking up the stairs and left knee 'buckled'." (RX1)
3. Employee's Notice of Injury, January 8, 2015—Petitioner wrote, "I stepped down onto step and knee 'buckled', gave way." (RX2)

4. Supervisor's Report of Injury, January 12, 2015—Duane Spencer wrote, "Marcus Shane Walker reported that he was helping his co-worker Don Morehead lift a ladder in Morris Library when his left knee allegedly gave out." (RX3)
5. Ferreli Hospital/Strictly Rehab, physical therapy initial evaluation, January 20, 2015—The therapist wrote, "Patient reports that he was at work and stepping up steps and the knee gave way, buckled and went out on him." (PX3)
6. Eldorado Family Medicine, Accident Information form, March 16, 2015—Petitioner wrote, "Carrying ladder up stairs, knee gave out." (PX5)
7. The Orthopaedic Institute of Southern Illinois/Dr. Wood, Workers Compensation Information form, March 25, 2015—Petitioner wrote, "Carrying ladder up stairs, left knee gave out." (PX5)
8. Dr. Richard Lehman IME report, July 23, 2015—Petitioner reported "he stepped with his left leg onto ladder stairs and it gave way". (RX8)

In addition, during trial Petitioner was asked what happened with regard to his left knee as he was walking up the stairs. Petitioner testified, "Well, actually, I just felt a shift and a pop."

The Arbitrator finds Petitioner's history of his knee giving out or buckling as he was going up the stairs to be suspect. If the knee buckles, the leg bends and is no longer straight, and if the leg is no longer straight, then the body drops down. One would assume that if Petitioner's left knee actually gave out or buckled, then there would physiologically be a shift of his weight on the left side. One would also assume that there would be some corresponding shift in the weight of the 100 pound ladder he was carrying. Mr. Morehead was on the other end of the ladder that was being carried, and was behind Petitioner as they went up the stairs. He testified he did not see Petitioner stumble, fall, or misstep. Even if he did not see anything, it is reasonable to conclude that he would have felt the weight of the ladder shift if Petitioner's left knee buckled and his own body weight shifted. Mr. Morehead's statement on his Witness Report was, "I never noticed any change in him, as if injured." The Arbitrator finds it unlikely, if not impossible, for Petitioner's knee to have physically gone out or buckle, and Mr. Morehead to have not noticed any shift in the weight of the 100 pound ladder on the other end.

Arguendo, if Petitioner's knee did in fact give out while going up the stairs, the Arbitrator turns to the medical evidence to determine the cause for it to have given out, and the cause of the resulting injury. Dr. Wood conceded on cross-examination that an osteochondral defect, when traumatic in nature, was usually caused by a twisting or direct impact. He then testified that walking up a step, carrying something, and the knee giving out, could cause an osteochondral defect, as it could cause a shearing force within the knee. In other words, the defect was due to a trauma, and the trauma was Petitioner's knee going out, or buckling. His opinion presumed that Petitioner's knee did, in fact, buckle or give out. He did not, however, testify as to what actually would have caused Petitioner's knee to give out. He made no reference to the weight of the ladder or the condition of the stairs. He conceded on cross-examination that Petitioner's weight of 270 pounds on his five foot ten inch frame created a load on his knee that would lead to faster degeneration in the knee. He conceded that Petitioner's BMI of 38.7 put him in the morbidly obese category and that it was common for someone of his size to have problems in both knees, and he acknowledged that Petitioner had a history of multiple surgeries and problems with his right knee, including an osteochondral defect. Dr. Wood testified it was possible Petitioner had just experienced pain on the date of the reported accident, and that the incident had not actually

caused the osteochondral defect. He further testified that what he found during surgery looked traumatic, and that "something traumatic" had occurred. Dr. Wood's opinion as to causation is based upon Petitioner's history that his knee buckled as he was going up the stairs. If the knee did not buckle, as addressed by the Arbitrator above, what caused the osteochondral defect?

The Arbitrator relies upon Dr. Lehman's testimony in answering this question. Dr. Lehman testified that Petitioner had a full thickness cartilage defect in his left knee, and that he had previously had the same problem in his right knee. He testified that when this defect is in both knees, it is considered symmetrical and is consistent with a degenerative arthritic process. He interpreted the MRI as showing arthritic changes, which took many years to develop, but he found nothing on the MRI that suggested an acute component of Petitioner's left knee. Like Dr. Wood, he testified that Petitioner's weight of 290 pounds and his accentuated BMI of 41.6 put him in the morbidly obese category, which stressed his knees. Dr. Lehman testified that a person with a BMI of 40 or 41 had an 85% or better chance of having degenerative arthritis at Petitioner's age.

Dr. Lehman went into great detail about the biomechanics of walking up a step. He explained that stress dissipated is in the patellofemoral joint underneath the knee, the kneecap. Most of Petitioner's problems, however, were on the medial aspect of his knee, in the tibiofemoral joint. He explained that the knee is made to go up and down stairs and to carry things. He did not believe walking up steps could be the mechanism of injury for the kind of damage that was found in Petitioner's knee. His opinion did not change when cross-examined regarding the weight of the ladder that was being carried, as the stress of that weight was dissipated in the kneecap. He explained you would not expect the damage found on the medial side of the knee, nor would you expect thinning that was seen in the patellofemoral joint, from simply walking up stairs. The Arbitrator finds compelling Dr. Lehman's testimony that "the disease process is totally incongruous with the history". He conceded that a traumatic injury could aggravate someone's arthritis to the point of making it symptomatic, but only if there was a true traumatic injury, such as a twisting injury or a deceleration where the foot is planted and the body twists. He opined that there was not such a traumatic injury in this case, and the Arbitrator agrees. The Arbitrator finds Dr. Lehman's testimony to be compelling.

The medical evidence is overwhelming as to the extent of Petitioner's arthritic condition in his left knee, especially in light of the extent of his previous problems in the opposite knee, and the extent to which his weight and BMI contributed to these problems. The condition for which Petitioner was treated was not caused or aggravated by his employment.

The Arbitrator found Petitioner to be less than credible with regard to four areas of testimony in particular. First, he testified and reported to his medical providers that his knee buckled or gave out as he was going up stairs. Yet, as discussed in detail above, Mr. Morehead was right behind him carrying the other end of the ladder, and did not see Petitioner stumble, fall, or misstep. Even if he did not see anything, it would make sense that he would have felt some shift in the weight of the ladder if such knee buckling had occurred. Second, Petitioner testified he did not say anything to Mr. Morehead at the time he hurt his knee because he "didn't want anyone to know". Although he may not have said anything, he was observed by Mr. Morehead while carrying the ladder up and back down the stairs, after they were done with that particular

job, and again when Mr. Morehead took him to the bus stop. At no time did Mr. Morehead observe anything out of the ordinary with the way Petitioner was walking or otherwise behaving. In fact, he reported on the Witness Report that Petitioner "was walking fine". Yet, after Petitioner had been home, woke up on his couch about 1:30 or 2:00 a.m. and got up to use the restroom, he could not put weight on his leg. The Arbitrator finds Mr. Morehead's observations to be compelling and further finds his testimony to be more credible than that of Petitioner. Third, Petitioner testified that he was told the lamper position was going to be permanent. Yet, both Mr. Morehead and Ms. Batson testified it was a temporary contract while the permanent lamper was out on leave. In addition, Petitioner knew nothing about the state exam that was required before a person could become a permanent full time employee, and he admitted on cross-examination that when he started the lamper job he was "given an end date". Fourth, Petitioner testified he had been looking for a job but had been unable to find one, and that he needed vocational assistance in that regard. However, as the Arbitrator noted above, the purported job logs have no dates on them, either on the individual employer lines or at the top of the pages. In addition, it appears only five of the 28 employers were contacted in person, versus by phone, and only four job applications were actually completed. This does not appear to be a good faith effort at finding employment, and Petitioner's testimony regarding same is viewed as less than candid.

Based upon the foregoing and the record in its entirety, the Arbitrator is not convinced that Petitioner's knee buckled while going up the stairs on the day in question, as discussed in detail above. The Arbitrator finds Petitioner failed to prove by a preponderance of the evidence that he sustained an accident on December 23, 2014, that arose out of and in the course of his employment. All other issues are rendered moot and the Arbitrator makes no findings regarding same.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rahshun Miller,
Petitioner,

vs. No. 14 WC 33271

State of Illinois, Dept. of Transportation,
Respondent.

18IWCC0196

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, 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.

Petitioner testified that on June 27, 2014 he had been employed as an Engineering Technician for Respondent for 13 years. The vast majority of his duties involved repetitive use of his hands at a computer, which he used to make highway drawings. He estimated he spent 90% of his time at work entering data into a computer. He did take occasional breaks, and performed other tasks away from his computer such as answering the phone, reviewing spec books and occasionally doing work in the field.

In May 2014 Petitioner first noticed tingling and numbness in the fingertips of both hands, and occasional sharp pain shooting from his right elbow to his pinky finger. He sought treatment with Dr. Joseph Eckert, his primary physician, who ordered an upper extremity NCV test. That test suggested right carpal tunnel syndrome. When Petitioner asked Dr. Eckert for a note stating his carpal tunnel syndrome was related to his work activities, Dr. Eckert deferred to Dr. S. Vic Glogovac, the surgeon to whom Dr. Eckert referred Petitioner.

Petitioner saw Dr. Glogovac only once, August 5, 2014. Dr. Glogovac diagnosed bilateral carpal tunnel syndrome, which he found to be "notable" on the right, but "less so" on the left. Dr. Glogovac offered no opinion regarding the etiology of Petitioner's carpal tunnel syndrome.

Petitioner then switched primary physicians to Dr. Philip Chu, who reported on August 19, 2014, "Carpal tunnel is very likely work related." Dr. Chu referred Petitioner to Dr. Kosit Prieb, who performed a right carpal tunnel release on October 8, 2014, and a left release on November 15, 2014. Petitioner was off work for those surgeries from October 8, 2014 through January 4, 2015.

Dr. Prieb testified at a May 6, 2015 deposition that Petitioner gave a history of spending most of his 40-hour work week typing on a computer. Dr. Prieb did not go to Petitioner's work site, see photos of it, or know the number or duration of breaks which Petitioner took during the day. Dr. Prieb opined that Petitioner's work activities could cause or aggravate his bilateral carpal tunnel syndrome. He further opined the carpal tunnel surgeries he performed were causally related to Petitioner's work activities. Regarding Petitioner's right elbow, Dr. Prieb diagnosed that condition as tendinitis, which he believed was helped by Motrin. Petitioner never returned to Dr. Prieb for treatment to his right elbow, and Dr. Prieb offered no opinion that Petitioner's right elbow condition was causally related to his repetitive work activities.

At Respondent's request, Dr. Ryan Calfee conducted a Section 12 exam on Petitioner on July 1, 2015. He also reviewed Petitioner's pertinent medical records and job description. He concurred that Petitioner's diagnosis was carpal tunnel syndrome, and that Petitioner's treatment was appropriate. However, he did not believe Petitioner's computer work caused his carpal tunnel syndrome because while it was repetitive, Petitioner's job duties involved no substantial heavy lifting or use of vibrating equipment. Dr. Calfee did not believe that there was any strong evidence that office-type work using a computer would produce or accelerate carpal tunnel syndrome. He also believed Petitioner's diabetes and elevated body mass index of 34.8 were conditions which have been associated more frequently with carpal tunnel syndrome. Dr. Calfee offered no causation opinion regarding Petitioner's right elbow, and after performing an AMA Disability rating of Petitioner, he determined Petitioner had a 0% impairment of his right upper extremity, and a 1% impairment of his left upper extremity.

Petitioner offered into evidence a copy of his Employee Notice of Injury form, in which he reported, "Numbness & tingling in hands and fingers on 6/27/14 [from] repetitive use of CADD machine and typing." He also offered the June 30, 2014 report of his supervisor, Gwen Lagermann, which noted, "Parts of Body Injured: Wrists – carpal tunnel syndrome." Neither of those reports mentioned injury or symptoms to Petitioner's right elbow.

The Arbitrator found Petitioner's right elbow and bilateral carpal tunnel conditions were casually related to a repetitive trauma work injury of June 27, 2014. The Arbitrator awarded Petitioner 12-5/7 weeks of temporary total disability (October 8, 2014 through January 4, 2015), reasonable and necessary medical expenses of $29,309.93, and permanent partial disability of 10% each hand and 2½% right arm under §8(e) of the Act.

Bilateral Carpal Tunnel Syndrome

The Commission finds the causation opinions of Dr. Chu and Dr. Prieb more persuasive than Dr. Calfee's. Petitioner used his hands repetitively at a computer for most of his workday. Although Dr. Prieb neither visited Petitioner's work site nor knew the number of breaks he took from keyboarding, that does not require Dr. Prieb's causation opinion be disregarded, given Petitioner's testimony and histories of spending 90% of his workday at his computer. The Commission does not consider Petitioner's requests to his treaters for causation reports to be a reason to disregard their opinions, as it is reasonable to conclude that they would not have provided such opinions had they not believed them to be true.

While other factors may have contributed to Petitioner's bilateral carpal tunnel syndrome, the Commission finds that Petitioner's repetitive keyboarding at work was a contributing cause of his condition. The Commission finds, after review of all the evidence, that the Arbitrator's award of 10% loss of use of each hand was appropriate.

Right Elbow Condition

The Commission views the evidence regarding Petitioner's right elbow condition differently than did the Arbitrator. While Drs. Chu and Prieb both opined Petitioner's carpal tunnel syndrome was causally related to his repetitive work activities, neither opined that his right elbow condition – described in the records as both cubital tunnel syndrome and tendinitis – was causally related. There was no mention of a right elbow injury or symptoms in Petitioner's initial treating records, his Notice of Injury form or his Supervisors Report. Dr. Prieb testified that Petitioner's right elbow complaints abated with the use of Motrin, and that Petitioner never returned to him for elbow treatment. The Commission finds that Petitioner failed to prove any right elbow condition was causally related to his work activities, and that he is not entitled to any medical expenses or permanent partial disability relating to any right elbow condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 11, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

18IWCC0196

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of medical expenses is modified. The Commission vacates the Arbitrator's award of medical treatment related to Petitioner's right elbow. Respondent shall pay Petitioner only the reasonable and necessary medical expenses related to his left and right wrists and hands, as provided by §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of 2½% loss of use of the right arm is vacated. Respondent shall pay Petitioner permanent partial disability benefits of $612.10 per week for a period of 38 weeks, as provided in §8(e)9 of the Act, because the injuries sustained caused a 10% loss of use of the right hand (19 weeks) and a 10% loss of use of the left hand (19 weeks).

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 because 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: MAR 30 2018

o-01/31/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MILLER, RAHSHUN
Employee/Petitioner

Case# **14WC033271**

SOI/IL DEPT OF TRANSPORTATION
Employer/Respondent

18IWCC0196

On 8/11/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0071 BONIFIELD & ROSENSTENGEL PC
JON E ROSENSTENGEL
16 E MAIN ST
BELLEVILLE, IL 62220

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

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

AUG 11 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

☐ 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

RAHSHUN MILLER
Employee/Petitioner

v.

SOI/IL DEPT. OF TRANSPORTATION
Employer/Respondent

Case # 14 WC 33271

Consolidated cases: N/A

18IWCC0196

An *Application for Adjustment 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 K. Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **08/19/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0196

FINDINGS

On **06/27/14**, 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 **$53,048.86**; the average weekly wage was **$1,020.16**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $29,309.93, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner temporary total disability benefits of $680.11/week for 12 5/7 weeks, commencing 10/08/14 through 01/04/15, as provided in Section 8(b) of the Act.

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 **$612.10**/week for **44.325** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **10 % loss of the right hand (19 weeks), 10 % loss of the left hand (19 weeks), and 2.5% of the right arm.**

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

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

Signature of Arbitrator

08/4/16
Date

AUG 11 2016

FINDINGS OF FACT

Petitioner, Rahshun Miller, works for respondent, Illinois Department of Transportation, as a senior design technician. In that position he aids in the design and construction of highways for the State of Illinois. Petitioner testified that this is a hand-intensive job with the vast majority of the time spent at the computer. He has worked for respondent for 13 years in the same position.

October 1, 2014, Petitioner filed an Application for Adjustment of Claim with the Illinois Workers' Compensation Commission, listing the Illinois Department of Transportation as the Respondent and alleging an accident on June 16, 2014 due to "CAD Engineer - repetitive trauma 13 years" causing "Bilat carp tunn & cubital tunnel requiring surgery" in "Both hands, arms & R elbow." (AX 2)

Petitioner first sought medical treatment on June 27, 2014 when he saw Dr. Joseph Eckert, a primary care physician at Chambers Medical Group. Dr. Eckert noted Petitioner was complaining of tingling in his fingers and diagnosed bilateral "probable carpal tunnel." (PX 2, P 7)

On June 30, 2014, Petitioner filled out an Employee's Notice of Injury, stating that his "typing, drafting" and "repetitive use of CAD machine and typing" had caused "numbness and tingling in hand and fingers." Petitioner listed the Date of Injury or Illness as June 27, 2014. (RX 1)

Petitioner returned to Dr. Eckert on July 2, 2014 and Dr. Eckert noted he still had tingling in his right and left hands. Dr. Eckert noted Petitioner did not have any swelling or an injury. Dr. Eckert noted Petitioner used a computer and designed highways. Dr. Eckert noted Petitioner had been scheduled for an EMG. (PX 2, P 8) On July 15, 2014, Petitioner underwent an EMG at Gateway Regional Medical Center. (PX 5, RX 6, P 3)

Petitioner returned to Dr. Eckert on July 25, 2014. Dr. Eckert noted Petitioner had mostly right hand numbness and that his EMG had been positive for carpal tunnel. As such, Dr. Eckert noted he would refer Petitioner to Dr. Glogovac. (PX 2, P 9)

On August 5, 2015, Petitioner saw Dr. Vic Glogovac. Dr. Glogovac diagnosed notable right carpal tunnel syndrome, less so on the left, and a right cubital tunnel syndrome. Dr. Glogovac noted Petitioner did not feel his splint for the right wristwas helping much at night, but he was to continue wearing it. Dr. Glogovac added an anterior pad to the right elbow and prescribed Petitioner a left cock-up splint, as well. Dr. Glogovac's record references possible surgery on August 29, 2014 for R carpal and R cubital tunnel releases pending workers'compensation authorization. A subsequent note from August 19, 2014 notes "Mr. Miller called and cancelled surgery – pursuing work comp." (PX 3)

On August 19, 2014, Petitioner saw Dr. Dr. Philip Chu, a primary care physician at Fairview Heights Medical Group. Petitioner testified that in an effort to be closer to home, he switched family physicians and saw Dr. Chu. Dr. Chu diagnosed Petitioner with carpal tunnel syndrome and referred him to Dr. Mirly or Dr. Prieb for an evaluation. Dr. Chu noted "carpal tunnel is very likely work related." (PX 4; RX 7, P 23-26)

On August 28, 2014, Petitioner first saw Dr. Kosit Prieb, a surgeon at Vascular and Hand Surgery, Ltd. Dr. Prieb noted Petitioner complained of numbness, pain and tingling in both hands and at the right elbow for the past two months. Dr. Prieb noted Petitioner was wearing his splints at night, but was not taking anti-inflammatory medication. He reviewed Petitioner's 7/15/14 EMG and diagnosed Petitioner with "bilateral

carpal tunnel syndrome" and started him on Motrin 400 mg three times per day. Dr. Prieb asked Petitioner to continue wearing his wrist splints and to return in two weeks for a follow up. (PX 5; RX 3, P 3)

Petitioner returned to Dr. Prieb on September 11, 2014. Dr. Prieb noted the Motrin and splints did not provide any relief. As such, Dr. Prieb recommended right carpal tunnel release. Dr. Prieb also noted, "Doing same job for 13 years. Using hands all the time. Possible work related or aggravation by his work." (PX 5; RX 3, P 6)

On October 8, 2014, Petitioner underwent a "decompression of right carpal tunnel" with Dr. Prieb at St. Elizabeth's Hospital. (PX 5; RX 4)

On October 16, 2014, Petitioner returned to Dr. Prieb, noting that his cast had been pushing on his palm. As such, Dr. Prieb discontinued the use of Petitioner's splint and prescribed Petitioner #30 Vicodin. (RX 3, P 10)

Petitioner saw Dr. Prieb again on October 23, 2014. Dr. Prieb noted Petitioner had much less numbness in his right hand since surgery. Dr. Prieb's Impression was status/post decompression of right carpal tunnel with good results. As such, Dr. Prieb scheduled Petitioner' left carpal tunnel release. (RX 3, 11)

On November 5, 2014, Petitioner underwent a "decompression of left carpal tunnel" with Dr. Prieb at St. Elizabeth's Hospital. (PX 5; RX 4)

Petitioner returned to Dr. Prieb's office on November 20, 2014 to have his sutures removed from his left hand. It was noted Petitioner had no pain, swelling or drainage. Petitioner was told to call with signs of an infection. (PX 5; RX 3, P 16)

On December 29, 2014, Petitioner returned to Dr. Prieb, who noted that Petitioner no longer had any numbness in his hands. Dr. Prieb noted Petitioner's right grip strength is 55 pounds and 55 pounds on two tests, and the left grip strength is 30 pounds and 30 pounds on two tests. Dr. Prieb released Petitioner back to full duty work on January 5, 2015 and asked to see him back in six weeks. (PX 5; RX 3, P 19) Petitioner was off work from the date of his first surgery on October 8, 2014 through January 4, 2015 on the recommendation of Dr. Prieb.

On February 17, 2015, Petitioner returned to Dr. Prieb for the final time. Dr. Prieb noted Petitioner had undergone bilateral carpal tunnel syndrome releases. Dr. Prieb's Impression was "status post decompression, bilateral carpal tunnel, with good results" and he released Petitioner from his care without restriction. (PX 5; RX 3, P 25)

Petitioner has received no further treatment for his bilateral wrists or his right elbow

The record contains evidence regarding Petitioner's job duties. A job description prepared by Respondent contains a job description for the senior design technician position. (RX 2, PX 6) In addition to the official written description Petitioner's supervisor, Gwen Lagemann, a Senior Design Squad Leader and Engineer for the Illinois Department of Transportation, sent an e-mail containing a typical work week for Petitioner. (RX 9, P 9) Petitioner reviewed the e-mail and the job description and agreed with both. As

indicated above, Petitioner testified that this is a hand-intensive job with the vast majority of the time spent at the computer.

The Arbitrator finds the "typical work week" prepared by Gwen Lagemann significant. Ms. Lagemann wrote:

> A typical work week for Rahshun Miller would include:
>
> Drawing in CAD files/importing schedules/SOQ (60% - 22.5 hours/week)
> Researching microfilm/old CAD files/old plan sets (5% - 2 hours/week)
> Preparing schedules by hand/in spreadsheets (20% - 7.5 hours/week)
> Reviewing policy, standards and spec book (3% - 1 hour/week)
> Coordinating with other sections/Bureaus by phone/e-mail/memo (5% - 2 hours/week)
> Answering questions from Construction (2% - 0.5 hours/week)
> Field Work (5% - 2 hours/week)... (RX 9, P 9)(emphasis added)

As the underscored time estimates indicate that Petitioner worked at a computer up to 35 hours in a 40 hour work week.

Dr. Prieb testified by deposition. (PX 5) Dr. Prieb testified that he first saw Petitioner on August 28, 2014 and that Petitioner stated he had numbness, pain and tingling in both hands and right elbow since June of 2014. (PX 5, P 6) Dr. Prieb testified that Petitioner's 7/15/14 EMG was inconclusive, but that Dr. Prieb performed an ultrasound on Petitioner's right and left wrists that showed dilated median nerves at both wrists, which suggested nerve compression at both wrists at the carpal tunnel levels. (PX 5, P 8-9) His diagnosis was bilateral carpal tunnel syndrome and right elbow tendonitis. *Id.*, at 13. Dr. Prieb indicated that Petitioner was temporarily and totally disabled from the date of his first surgery on October 8, 2014 through January 4, 2015. *Id.*, at 12. Dr. Prieb also stated that he had given Petitioner an anti-inflammatory (Motrin) for his elbow pain, which he called tendinitis, but that it must have improved, as Petitioner did not ever come back to him for that. *Id.*, at 10, 13. Dr. Prieb testified that he has no plans to see Petitioner in the future, as he asked Petitioner to return as needed and Petitioner had not been back since February 17, 2015. *Id.*, at 14.

Dr. Prieb opined that Petitioner's job duties, specifically his work on the computer, more probably than not contributed to cause or aggravate his carpal tunnel syndrome. *Id.*, at 9-10. On cross examination Dr. Prieb was questioned regarding the extent of his understanding of Petitioner's job duties. Dr. Prieb indicated it was his understanding that Petitioner's "main work, main occupation, typing. He might not be typing all the time, but, you know, that's his work, so most of the time he'd be doing the work with the computer, typing." Dr. Prieb understood that Petitioner did not work at a computer each minute of every day. He knew Petitioner would periodically retrieve physical files, speak on the telephone and perform other activities to gain information needed in his computer work. *Id.*, at 15-18. Dr. Prieb also testified that Petitioner's treatment for bilateral carpal tunnel syndrome was related to his work activities. *Id.*, at 11. The Arbitrator finds that Dr. Prieb's understanding of Petitioner's job duties was consistent with the "typical work week" prepared by Gwen Lagemann. Working with a computer up to 35 hours in a 40 hour week indicates that Petitioner indeed perform work with a computer for the vast majority of the time he was at work.

On July 1, 2015, Petitioner underwent a Section 12 examination at the Respondent's request by Dr. Ryan Calfee. (RX 8) Dr. Calfee produced a report outlining his opinions, after performing a physical examination of

Petitioner and reviewing documents provided to him by Respondent, including the email from Petitioner's supervisor, Gwen Lagemann, which described Petitioner's job duties. Dr. Calfee also spoke to Petitioner about his job duties, stating "[t]his gentleman has worked an engineer technician for 13 years he says in the same position. He works 40 hours per week. He largely does computer work for most of the day he describes. He says there is occasional fieldwork, but most of his job involves putting information into computers." (RX 8).

Dr. Calfee performed a physical exam of Petitioner after which he noted full range of motion in the fingers and full supination and pronation. Elbow motion was full. Wrist motion on the left was 70 degrees of extension, 60 degrees of flexion. On the right motion was 70 degrees of extension and 70 degrees of flexion. Grip was 82 pounds on the right, 92 pounds on the left. He found no subjective numbness, noted well-healed carpal tunnel incisions in both palms without any excessive scar tissue or tenderness, and no muscular atrophy.

Dr. Calfee opined Petitioner's current diagnosis is bilateral carpal tunnel syndrome status post bilateral carpal tunnel release. He failed to address the right elbow. He felt Petitioner's current objective findings are consistent with his report that his subjective complaints have largely resolved. He has normal two-point sensibility and no muscular atrophy. His incisions are nicely healed and provocative signs around the median nerves are now negative. His intermittent pain on the left side would not be expected to produce any objective findings on examination today. His medical records support his diagnosis and appropriate treatment.

Dr. Calfee, however does not believe that Petitioner's job duties caused, aggravated or accelerated his nerve compression condition. Dr. Calfee noted that "from the patient's history and his records it appears that his job is largely sedentary with routine use of a computer mouse and writing. His job does not entail substantial heavy lifting or use a vibratory equipment [sic]. I do not believe that there is strong evidence that office-type work using a computer is going to produce or accelerate carpal tunnel syndrome. *Id.*, at 8. He felt that Petitioner is at maximal medical improvement and does not require any restrictions regarding his hands, wrists or forearms. He is already back working full duty without restriction and should be able to continue to do so. *Id.* Dr. Calfee prepared an AMA rating for Petitioner's bilateral carpal tunnel syndrome. He indicated on Mr. Miller's right side, he has had a conduction delay by electro-diagnostic testing, but now has no symptoms and normal physical examination findings. Therefore, I do not believe that he has any impairment of the right upper extremity. On the left side, nerve conduction testing was normal, although ultrasound had positive findings. He has mild intermittent symptoms at this point with a normal physical examination. I would estimate that he has a 1% permanent partial impairment of the left upper extremity as a result of his left carpal tunnel syndrome that has been treated with surgery. *Id.*

At the time of hearing Petitioner testified that a couple times a week he will get a stinging pain if he lifts something heavy. He also testified that occasionally he gets a little pain if he grips something too hard.

CONCLUSIONS

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

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

An injury is accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Industrial Commission*,

128 N.E.2d 718, 720 (Ill. 1955); *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (Ill. 1982). In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture,* 99 I.I.C. 0961 (1999). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003) (emphasis added). As in establishing accident, to show causal connection Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd Dist. 2000).

In *Edward Hines Precision Components v. Indus. Comm'n,* 825 N.E.2d 773, (2nd Dist. 2005). the Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Id.* at N.E.2d 780. Similarly, the Commission recently noted in *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before a finding of repetitive trauma can be made. *Randell* citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (2nd Dist. 1991) and *Edward Hines supra.*

The Appellate Court in *City of Springfield v. Illinois Workers' Comp. Comm'n*, 901 N.E.2d 1066 (4th Dist., 2009) issued a favorable decision in a repetitive trauma case to a claimant whose work was "varied" but also "repetitive" or "intensive" in that he used his hands, albeit for different tasks, for at least five (5) hours out of an eight (8) hour work day. *Id.* "While [claimant's] duties may not have been 'repetitive' in a sense that the same thing was done over and over again as on an assembly line, the Commission finds that his duties required an intensive use of his hands and arms and his injuries were certainly cumulative." *Id.*

In this case, the evidence shows that Petitioner used his hands and arms extensively during the performance of his job duties for Respondent. Further, the Arbitrator finds the opinions and testimony of Dr. Prieb much more persuasive than those of Dr. Calfee in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he sustained accidental injuries which arose out of and in the course of his employment with Respondent and that his current condition(s) of ill-being are causally related to the employment.

Issue (D): What was the date of the accident?

The Workers' Compensation Act is a humane law of a remedial nature that should be liberally construed to achieve its purpose. *Hagene v. Derek Polling Const.*, 388 Ill. App. 3d 380, 902 N.E.2d 1269 (2009). Hence, the Supreme Court has established a flexible but fair standard for determining manifestation dates in repetitive trauma claims. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007). Although the date on which the employee becomes aware that he has a condition related to work was the first method for determining a manifestation date, it is not the only permissible means for alleging or proving manifestation. The manifestation date can be set as: (a) the date the employee actually became aware of the physical condition and its relation to work through medical consultation; (b) the date the employee requires medical treatment; (c) the date on which the employee can no longer perform work activities; or (d) when a reasonable person would have

plainly recognized the injury and its relation to work. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007), *see also Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026 (Ill. 1987); *Oscar Mayer & Co. v. Industrial Commission*, 176 Ill.App.3d 607, 531 N.E.2d 174 (3rd Dist. 1988); *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989). The Supreme Court in *Durand* noted that the manifestation date is typically set on the date the employee requires medical treatment or the date on which the employee can no longer perform work activities. *Durand,* 862 N.E.2d at 929. T

In *Linda Peters v. Village of Caseyville*, the Commission set a manifestation date different from that to which the parties stipulated. *Linda Peters v. Village of Caseyville*, 14 I.W.C.C. 0796 (2014). The Commission stated:

> The Commission finds that the manifestation date of Petitioner's right carpal tunnel syndrome was March 1, 2012. Although the parties had stipulated to an accident date of September 1, 2010, we find that it is within our discretion to change the accident date to conform-to the evidence. *See Beal v. Town of Normal*, 10 IWCC 380 (2010). The medical records are clear that the first mention of any correlation between Petitioner's right carpal tunnel syndrome and her work duties is the March 1, 2012, office note of Dr. Mirly. Although Petitioner's report of injury on March 2, 2012, indicates a date of accident of "Sept 2011," we find that this is not an appropriate manifestation date in this case because Petitioner did not have a confirmed diagnosis at that time. *Id.*

In this case Petitioner filed an Application for Adjustment of Claim on October 1, 2014 alleging an accident on June 16, 2014 due to "CAD Engineer - repetitive trauma 13 years" causing "Bilat carp tunn & cubital tunnel requiring surgery" in "Both hands, arms & R elbow." (AX 2) Petitioner first sought medical treatment on June 27, 2014 when he saw Dr. Joseph Eckert, a primary care physician at Chambers Medical Group. Dr. Eckert noted Petitioner was complaining of tingling in his fingers and diagnosed bilateral "probable carpal tunnel." (PX 2, P 7) On June 30, 2014, Petitioner filled out an Employee's Notice of Injury, stating that his "typing, drafting" and "repetitive use of CAD machine and typing" had caused "numbness and tingling in hand and fingers." Petitioner listed the Date of Injury or Illness as June 27, 2014. (RX 1)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that June 27, 2014, the date Petitioner first sought treatment for his upper extremity symptoms, is an appropriate manifestation date under the Act.

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?

Petitioner's Exhibit 1 contains the medical bills incurred by petitioner as a result of his treatment for bilateral carpal tunnel syndrome and right elbow tendonitis. The total of the expenses is $29,309.93. Both Dr. Prieb and Dr. Calfee agree that the treatment Petitioner received was reasonable and necessary. The dispute was as to Respondent's liability for payment in light of issues C and F above. Having ruled in Petitioner's favor with regard to those issues, Respondent shall pay reasonable and necessary medical services of $29,309.93, 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.

Issue (K): What temporary benefits are in dispute?

It is undisputed that Petitioner was temporarily and totally disabled from 10/08/14 through 01/04/15. The dispute was as to Respondent's liability for payment in light of issues C and F above. Having ruled in Petitioner's favor with regard to those issues, Respondent shall pay Petitioner temporary total disability benefits of $680.11/week for 12 5/7 weeks, commencing 10/08/14 through 01/04/15, as provided in Section 8(b) of the Act.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 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 Dr. Calfee assessed Petitioner's impairment rating at 1% of the left and 0% of the right upper extremity. However, impairment does not equal disability. The impairment rating is part of the determination for permanent partial disability benefits, but is not the sole or main factor. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner continues to work as a senior design technician. In that position he aids in the design and construction of highways for the State of Illinois. This is a hand-intensive job with the vast majority of the time spent at the computer. Petitioner experiences periodic symptoms in his bilateral wrists. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 41 years old at the time of his injuries. He has many years remaining in the work force and will have to deal with the conditions for more time than an older worker. 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 the Petitioner was a credible witness. Petitioner has had successful treatment of bilateral carpal tunnel syndrome as well as right elbow tendonitis. Petitioner still feels a stinging and pain in his hands from time to time when he lifts anything heavy. Likewise, petitioner occasionally feels a sharp pain in his right elbow when he lifts certain objects. The Arbitrator therefore gives *some* 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 10% loss of use of each hand and 2.5% of the right arm pursuant to §8(e) of the Act.

Respondent shall pay Petitioner the sum of $612.10/week for 44.325 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 10 % loss of the right hand (19 weeks), 10 % loss of the left hand (19 weeks), and 2.5% of the right arm.